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ETHICAL PECULIARITIES OF RENDERING

FIRST MEDICAL AID IN EMERGENCIES

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ETHICAL PECULIARITIES OF RENDERING FIRST MEDICAL AID IN EMERGENCIES

Introduction

EMERGENCIES IN MODERN WORLD AND CONTEMPORARY MEDICAL ETHICS (BIOETHICS)

Joint participation of medical specialists from different countries in rendering timely medical aid plays essential role in the century of cataclysms and man-made disasters. However nowadays different approaches to rendering the first medical aid to victims exist in various countries of the world. As a result the assistance acceptable in some countries turns out to be unacceptable for the representatives of other countries and religions or certain confessions of faith. And similar problem can arise not only during the deployment of medical specialists in other countries but also during rendering first medical aid within such a multinational country as the Russian Federation. Competence of physician's actions, the type of his communication with local population (including health-care workers from local population), patients and members of their families, all these factors represent a big bioethical problem.

The brochure structure represents a stepwise description of general moral principles of rendering medical aid and its peculiarities in emergency medicine. After a concise description of emergency concept we will produce a set of universal ethical rules and principles of physician-patient relations. These principles and rules are included in many international and national ethical codes of medical profession. Universal Declaration on Bioethics and Human Rights (UNESCO,

2005) is of the most interest to us. The moral standards substantiating and regulating the values of humanitarian aid in disaster areas are the particularization of these principles. A lot of national and international organizations develop appropriate moral codes for their staff. Medicine is the most important but not the only type of humanitarian aid in emergency conditions. Therefore the international cooperation fundamentals in the field of humanitarian law are represented in this brochure. Further particularization of humanitarian aid moral standards is accomplished taking into account specific character of physicians' activities when rendering aid to affected population. General principles of these activities are stated in the Statement on Medical Ethics in the Events of Disasters (Stockholm, 1994) The final section of the brochure demonstrates the complexity of versatile rules and principles application in particular situations of rendering medical aid to the victims from various ethnic and religious groups. The necessity of taking into account local peculiarities is emphasized. We provide the full text of above mentioned Universal Declaration on Bioethics and Human Rights (UNESCO) and WMA Statement in the attachments.

The art of the physician who renders medical aid is expressed directly in ability to combine general regularity of illness development and medicinal agents' effects with individual peculiarities of a certain patient. The same situation is in bioethics. It is necessary to learn combining general principles stated in the declarations with peculiarities of unique cases of rendering medical aid in various cultural regions.

Emergency is a violation of normal life conditions and people's activity at a certain facility or in a specific territory, water area caused by an accident, catastrophe, natural or ecological disaster, act of terrorism or is the result of military operations that resulted in or can result in casualties or material losses.

The number of emergencies is characterized by constant increase. Meanwhile the number of man-made catastrophes inflates. The statistical data concerning emergencies on the territory of the Russian Federation for the past few years is given in Table 1.

Table 1
EMERGENCIES STATISTICS ON THE TERRITORY OF THE RUSSIAN FEDERATION

Years	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**6 months of 2010**
A total number of emergencies, *including:*	838	1134	2720	2847	2,693	2,146	424	160
man-made	518	863	2464	2541	2,248	1,596	270	87
natural	286	231	198	261	402	161	133	46
biological and social	15	28	48	44	43	37	21	15
major acts of terrorism	19	12	10	1	NA	NA	NA	12
Died, persons	1 161	2 459	5 637	6 043	5,199	4,441	734	361
Injured, persons	15 631	23 182	4 946 тыс.	8 150	27,335	7,484	2,428	1,105

NA – not available

In emergency the origination of complicated conditions of the situation is possible and it will affect the organization and implementation of medical aid activities. Traditionally conditions are the following:

— mass scale and contemporaneity (in a short space of time) of losses among population, various type and severity of injuries;

— dysfunction of medical institutions, utility and communication lines;

— possible contamination of vast areas, food, water with radioactive, chemical and bacterial agents;

— complicated sanitary and epidemiologic situation in the seats of mass destruction centre;

— need for health care resources and forces does not correspond to their availability.

Introduction

Shortage of resources of rendering medical aid to victims in emergency conditions determines one of the most complicated ethical problems. From our point of view the additional factors affecting the organization of urgent medical aid support are religious convictions of individuals. In fact cultural and religious environment has a great influence on the formation of patients' mind. Maintenance of health and life of a sick person or a victim should not be separated from observance of principles of personal freedom. Maintaining patient's health and saving his life can not be separated from observance of personal freedom principles and therefore the principle of respect for individual's convictions. It is evident that competent medical aid rendering is impossible without knowledge of cultural peculiarities in such a multiconfessional country as the Russian Federation and when providing medical and humanitarian assistance in other regions of the world.

CHAPTER 1

PECULIARITIES OF MODERN MEDICAL ETHICS (BIOETHICS)

What is Bioethics?

The term "bioethics" was suggested in 1970 by American oncologist Van Rensselaer Potter who considered the most topical the task of uniting the efforts of the humanities representatives and naturalists (outstanding biologists and physicians) for the purpose of ensuring the humanity survival in decent living conditions. According to Potter bioethics as "the science of survival should not be just a science but a new wisdom which would unite the most important and necessary elements – biological knowledge and universal values". At the first stage bioethics was developed in the USA. In the 80s it was recognized and its developing began in the Western Europe and Australia and since the 90s – in the countries of the Eastern Europe and Australia, including Russia, in Latin America and Asia (first of all in Japan and China).

The primary task of bioethics is to provide solutions to the most complicated moral problems caused by biomedical science and practice progress. Is the man's cloning allowed or not? Are the attempts to create a new "sort" of people who differ from "natural" people in their high physical and intellectual qualities by means of genetic methods acceptable? Is it necessary to ask permission from the family when taking organs for transplantation from the dead? Is it allowed and is it necessary to tell patient the truth about fatal illness? Is euthanasia a crime or an act of grace? These and similar questions arise in front of the humanity practically every day. Bioethics vacation is to give answers to them, to find morally substantiated and socially effective solution.

However one has a right to answer the question if over the period of centuries medicine and science solved such types of problems themselves why it was

necessary to develop bioethics. For example, everybody knows about Hippocratic Oath that for many centuries has been the base of physicians' professional ethics, about the leading physicists' role in the movement for nuclear weapons tests prohibition, about the role of biologists in the struggle for natural environment protection. Principal difference of bioethics from Hippocratic ethics is that the latter is of a purely corporate character. Its meaning comes to the physician's duty in front of the patient who according to the etymology of the word "patient" is passive and does not take part in elaboration of crucial decisions in the situations where he participates as a suffering individual. Bioethics proceeds from the idea of an "active patient" who as a moral subject has complicated dialogic (sometimes competitive) relations with other moral subjects – physicians and scientists. Each of them can possess his own moral principles.

Traditional values of mercy, charity, infliction of undiminished harm to patient, moral responsibility of scientists are not in the least abolished. They just get new sense and perception in a new cultural situation. Much more attention is paid to moral value of an individual as a unique and inimitable personality. In the centre of a moral mind the idea of person's *autonomy,* his *inalienable right* (consolidated in international and national legislation) to make the most important decisions concerning his own life in normal conditions as well as in case of illness are found.

It should be also noted that if physicians as experts possess the most direct knowledge, for example how to carry out rescue activities in mass destruction centres, what medical procedures should be applied in the first place, etc. then the question about their moral, religious and legal admissibility is beyond their professional competence. It requires to be considered in all its aspects. Therefore bioethics is developed by the representatives of many branches: physicians, biologists, philosophers, theologians, psychologists, sociologists, lawyers, politicians and many others. In this regard bioethics presents a complicated *interdisciplinary phenomenon.* The problems are so difficult that a joint effort of people possessing various types of knowledge and experience is necessary.

And another peculiarity of bioethics is that we live in pluralistic society. History shows how dangerous it is to try to impose the society with one system of ideological, national, religious and other values. We all differ in our value

preferences but nevertheless we are the citizens of one society, the representatives of one human kind. It is dangerous to seek to turn everyone into communists, members of the Orthodox Church, Catholics or Muslims. Therefore it is necessary to develop social skills of cohabitation despite the differences respecting the right to be different from the others and having respect for racial, cultural, religious and other peculiarities.

Hereupon bioethics does not just study moral problems caused by scientific and technical advance but participates in formation of different political institutions of pluralistic society and is a forum of discussion and concurrence of various moral prospects in the field of public health. Ethical committees acquired maximum value. Complicated bioethical problems deal with many aspects of development of modern societies. Therefore a special sort of social institution of ethical committees was established for their solution which is a multi-level network of public, state and international organizations. Ethical committees exist under research organizations and hospitals, professional associations (medical, sisterly, pharmaceutical), government organs (parliaments, presidents' administrations), international organizations (UNESCO, WHO, Council of Europe et al.). Members of the public connected with powerful human rights movement of various patient groups play essential role in the activities of these committees. The role of the public in development of bioethics is reflected in many international and national legislative acts.

Besides ethical committees it should be noted that bioethical ideas are developed and socially implemented within the scope of social movements diversity. It is enough to mention independent medical associations, organizations for patients' and animals' rights protection, supporters and opponents of the abortion right, etc.

The most important condition of fruitful social cooperation of people representing various forms of value orientations, knowledge and experience is the improvement of *bioethical education* quality. It should be noted that in Russia since 1999 bioethics has been introduced in the system of physicians' compulsory education. Also it is taught to the representatives of other health professions, biologists, philosophers and psychologists. Recently Russian and translated

tutorials have been published. Conferences and seminars are held. At the same time in spite of certain success the system of bioethical education is in nascent condition in our country. This brochure will not solve all the problems but as we hope it will favour the awareness of physicians participating in providing assistance in emergencies in the field of bioethics.

Health-Care Workers – Patients Relations Models

Modern medical practice represents a complicated differentiated system in which physicians and patients can have various forms of social interaction. Each of these forms reflects certain traditions of medical practice existing in present society.

In order to describe various variants of health-care workers – patients relations American philosopher Robert Witch singled out four basic models: engineering, pastoral (paternalistic), collegial and contract (contractual). These models are of unequal value according to their moral sense and represent the hierarchy from the least morally grounded engineering model to the most grounded contract model.

Engineering model. Within the scope of engineering model physician treats patient as an impersonal mechanism. Medical treatment task is interpreted as repairing body "damage" due to the effect of external or internal factors. In some cases instead of damage category the notion of physiological mechanism deviation from equilibrium position is used. Medical treatment consists in the fact that physician by means of certain physical actions strives for returning this mechanism into equilibrium position. Engineering model is based on the presentation of medical activity as the area of applied use of impartial neutral scientific knowledge that as a science should be "beyond good and evil".

Patient's good is recovered health which is described through the whole set of objective tests: biochemical rates, blood pressure rate, gas exchange rate, X-ray results, etc.

Robert Witch notes that engineering model is based on old-fashioned idea of scientific knowledge nature. Modern science philosophy convincingly demonstrates that objective knowledge «is loaded» with considerable amount of

premises of which the scientists are not aware, among which personal and group interests play an important role as well as certain moral preferences. Science is by no means indifferent. Hiroshima, "scientific" experiments in Nazi camps and tragic experience of genetics development in Russia clearly indicate the fundamental importance of moral and ethical principles in natural science. In public health technocracy, dominating within the scope of engineering model is morally defective since it brings down the personality of the sick to the status of inanimate subject.

As a matter of principle, the criticism of engineering model ideology is substantiated to the degree concerning moral aim of physician's or scientist's consciousness. Modern moral standard of medical actions directs in the strongest terms not to tolerate the depersonalization of patient's treating.

However is the "depersonalization" always the result of morally defective physician's treatment of a patient? The question is that in quite a number of wide-spread in modern medicine cases patient objectively can not figure as a personality. High level of labour division in modern hospital equipped with high-technology equipment results in making direct personal contact of attending medical physician, nurse and patient. A considerable amount of specialists is occupied with purely special procedures excluding the elements of personal contact with a patient.

For centuries medical treatment existed as the activity of a certain professional who is personally in contact with a patient, taking decisions and rendering aid. Nowadays ordinary situations exist when de facto it is not a certain physician who works with a patient but a collective subject (team). The activity of this collective subject is not personified in the context of interpersonal communication with attending medical physician. All others by force of their social role and position in the system of labour division have to fulfill more or less technical functions.

Depersonalization of the attitude towards a patient is in the result of immoral attitude not this case but the consequence of technocracy of contemporary medical practice. Ophthalmologic surgical production line in the clinic named after the Professor Svyatoslav Fyodorov where a surgical table with a patient during a

surgical operation moves from one surgeon to another and each executes one highly specialized manipulation clearly demonstrates the vital capacity of such model.

However one should not forget about the necessity of the fact that the work of medical collective subject at decisive moments for a patient could be personalized in morally important communication with attending medical physician, patient's family, representatives of his religious community, village elders, etc.

Pastoral or paternalistic model. Within the scope of paternalistic model physician-patient relations remind of paternal attitude towards a child or a priest towards a parishioner. In fact in this case the priest is traditionally named Father and the parishioner is called son or daughter.

Considerable progress in the moral transformation of physician-patient relations structure is obvious. This is no longer an impersonal manipulation with an object as it was observed in the engineering model. Paternalistic attitude is filled with personal meaning. It is motivated by the desire to help a suffering person and avoid injuring him.

Paternalistic treatment is formed as certain interpersonal communication. Its moral principles are love for neighbour, charity, mercy and justice. Although the personalities are not in equal position. Physician plays the role of "father" possessing certain scientific knowledge and being able to use it to help the patient. Patient plays the role of an ignorant child whose moral valour consists in disciplined accomplishment of prescriptions and recommendations of the "elder"

Paternalistic model prevailed in medicine for many centuries. It is clearly expressed in «Hippocratic Oath» and in the «Promise of Russian Physician». Paternalism in communication with patients remains the norm for considerable number of contemopary physicians and not so many patients appreciate paternalistic attitude towards themselves as the most appropriate.

What kind of imperfection does this model have from the moral point of view? According to Robert Witch's opinion paternalism infringes the rights of the patient as an independent personality who himself and freely makes vital decisions and controls his condition. Patient personal dignity is disparaged as far as the attitude is transformed from "horizontal" – equal in rights into "vertical" - subordinate. Figuratively the patient has to look up to the physician.

In the cases and for the matter of patient's ability to play the role of independent personality paternalistic violation of his rights is inadmissible from the moral point of view. However is it always possible within the scope of medical practice?

One could think that paternalism is the only and the most appropriate sort of physicians' attitude towards sick children and other patients with limited abilities. Also a considerable amount of people exists for whom physician's paternalistic attitude is psychologically the most acceptable. Their personal preference should be respected.

Paternalism is quite moral in a proper place, proper time and to proper extent. Definitely paternalism is not authoritarian attitude towards a patient. "Paternal" attitude towards a child should be changed as he grows up. So the physician's attitude towards a patient should be different according to the legal capacity degree of the latter and the physician should take into account his or her personal preparedness to responsible independent actions.

Collegial model. A collegial model of medical worker-patient relations creates a much larger space for implementation of autonomous personality values. Patients' role is interpreted in the same categories as the physician's role is. In order to play this role the patient should receive from the physician sufficient amount of truthful information concerning his health condition, treatment options, prognosis for a disease, possible complications, etc. The patient being to some extent equalized with physicians in respect of information awareness is now able to participate in working out certain solutions concerning his treatment. He realizes the inherent right of a personality for a freedom of choice acting as attending medical physician's colleague.

However such kind of harmony of interests is rarely achievable. Physician and patient can adhere to different value orientations; belong to different social classes and ethnic groups. The coincidence of interests is not frequently a rule but an exception from real social structure. For example in conditions of commercial medicine serious interest of physicians in expenses minimization and maximization of income exists, it usually contradicts patients' interests in maximization of available aid and minimization of personal costs for its receiving.

At the same time one should keep in mind that there is a significant domain where collegial physician-patient relations can exist. The matter is the cases of lingering chronic illnesses. A young physician who came to visit an elderly cultivated patient with diabetes has every reason to "leave his professional ambitions in the entrance hall". The volume of knowledge acquired by such patients during many decades of their illness in certain aspects can prove to be considerably more extensive than the one of a young or even not so young physician. Also their personal experience of reaction to certain medical treatment, provision, their experience of complications should be mentioned.

It is useful to take into account this circumstance when rendering aid to the victims of other ethnic and religious groups within the scope of emergencies.

In a similar situation physician-patient communication can approximate to the ideals of collegial model resembling professionals' consultation where the knowledge of one person supplement and specify the knowledge of another. The decision concerning one or another medical prescription is elaborated jointly.

Contract model. Speaking about the contract model of physician-patient relations Robert Witch means juridical content of conception "contract" (agreement) as well as more common "symbolic" content. Let's recall the meaning of the word "covenant" as it was used in the Bible.

Contract or agreement is a definite form of adoption of the interaction rules of various social parties. Contract peculiarity consists in the fact that these rules are freely elaborated by the parties on the basis of taking into account mutual interests. Entering into a contract the parties distribute the authorities between each other, establish reciprocal responsibility, and assign pursued goals and the means of their achievement. The breach of the contact by one of the parties gives the other the right for its termination. The desire of a well-known Dostoevsky's character "to return the ticket" to God is just the idea of unexecuted contract (Covenant).

The ideal of a contract as the most worthy of a man form of social relations was developed in the Age of Enlightenment. To replace inherited and as if given by God the power of a sovereign the Illuminators suggested the idea of social contract. They considered that the power should not belong exclusively to some group of people in virtue of their "breed" and class privileges. As a result of free expression

of popular will people have the right to delegate authority powers to a sovereign but meanwhile he enters with them into a contract which determines common objectives pursued by power and its authorities limits. Breach of a contract by the sovereign gives people grounds for its termination and deprivation the sovereign of its power. In modern communities not only macropolitical relations are arranged on contractual role distribution and mutual responsibility but working, family and other social relations.

What is attractive in contract model as an exemplary physician-patient relations structure? In Robert Witch opinion exactly this model defends the most the moral values of independent personality. Within the scope of contract model "… individuals and groups interact in such a way that each of the parties has certain obligations and derives some benefits… Main moral principles of freedom, dignity maintaining, truthfulness, allegiance to accepted obligations and justice are vital for contact relations realization".

Contract form of relations allows avoiding the shortcomings pernicious for patient's freedom which are characteristic of engineering and paternalistic models. Simultaneously it does not set hopes upon the illusion of possibility of patient's participation as a physician's "colleague". A patient voluntarily establishes a relationship with a physician on the terms which he considers beneficial. Meanwhile he is able to delegate certain "regulatory" powers to physician so he is able to fulfill adequately his professional obligations conditional on medical care contract. Contract model is more realistic. It takes into account the impossibility of physician-patient inequality that is inevitability of "vertical" dependence relations. At the same time this dependency is established under certain conditions. If these conditions are not fulfilled patient has the right to consider this contract invalid and to divest physician of the authorities that the latter received by virtue of the contract.

The idea of social contract determines (at least in principle) basic features of Russian health-care system functioning. The Constitution of the Russian Federation is the agreement between the society and the state. According to this agreement power is delegated to public authorities. In so doing objectives of exercising this power and its limits are established. Particularly, article 41 of the

Constitution establishes the right of every citizen for health protection and medical care. The state is delegated certain authority powers to implement certain objectives, including ensuring and protection of citizens' rights and the rights in the health-care field. However this power can be exercised only within certain limits. For instance article 21 reads "Nobody can make medical, scientific and other experiments on a person without his voluntary consent".

In Russian medicine practice the cases of conducting biomedical researches occurred, e.g. testing new vaccines on children without voluntary informed consent of their parents. However new vaccines development is a part of state policy directed at ensuring of citizens' constitutional rights in the health-care field. The Constitution creates the limits for this police protecting the right to security of person of certain citizens.

Laws adopted by the State Duma and decisions of national public authorities determine the levels of contractual relationships vesting rights and obligations in health-care agencies, establishing the rules of their possible interaction. Medical care contract with a medical institution that a certain citizen enters into personally or having delegated this right to an insurance company forms a sort of contractual relationships "iceberg top" where medical activities are formed.

Agreeing with Robert Witch about fundamental importance of his physician-patient relations models the utility of these models classification on different grounds should be noted. Taking contract model as an initial model it is easily noticeable that in terms of health-care activities organization it can be contrasted with *state health-care model* which existed in the USSR during 70 years and also exists in Great Britain, Canada and in a number of other countries at present. Unlike contract model within which the relations are arranged as a result of parties' agreement, in state model (this text concerns only soviet model) physician-patient relations are regulated by outside public health-care authorities. Assigned medical institution and assigned physician is "in charge" of a patient. In a way the state model reminds of a paternalistic one. A patient is passive and a physician decides himself what is good and what is bad for him guided purely by his medical considerations. However state paternalism has quite specific features.

Specific features of paternalism in state model consist in the fact that physician's status is also dependent in many respects. Medical profession does not possess necessary social, economic and legal independence and immunity. The danger of such situation is that medical workers can be used as an implementer of purely political objectives contradicting to moral standards of medicine. "Repressive psychiatry" practice is just extreme expression of medical workers' dependency. Dependency dramatically restricted physicians' possibility to realize those moral principles which they recognized theoretically. For example a physician really could not protect confidentiality of medical information concerning his patient from the "curiosity" of party, soviet and state authorities.

In this respect contract model presupposing supremacy in legal relations society is a serious progressive move in ensuring of the right of not only patients but medical workers themselves.

Principles and Rights of Bioethics — Attitude Towards a Patient as a Personality

Suffering that any being endures causes *the feeling of compassion in another person,* the desire to help, to give relief to a suffering person. Compassion is a sort of response to the *call* for help which is a *calling* of a certain kind or a moral base of two professions — veterinarian and physician. If this feeling has not developed yet or has deadened with age then it becomes difficult to talk about his moral qualities. It is no accident that compassion (as well as a very close in its meaning moral quality - mercy) has been considered principal medical virtue since earliest times.

Keeping in mind this important circumstance one must not forget about another circumstance — man's compassion and animal's compassion are not equal. Therefore physicians' and veterinarians' attitude towards suffering creatures should be different. It is precisely this circumstance that emphasizes fundamental demand of bioethics: *physician's moral obligation is to treat patient as a personality and patient's moral obligation is to remain a personality even in conditions of illness. It is difficult to respect the personality of the person who does*

not himself have respect for it. But what does it mean? The word "personality" has many meanings. There is no way philosophers can come to its realization.

However despite serious divergence of theoretical opinions long-term debates resulted in working out common language of discussion of this moral problem of modern biomedicine. A set of selected and vested moral concepts that are usually used for clarification of emerging situations and decision-making is of great importance for it. Grading with degree of community these concepts are for convenience divided into principles determining the most fundamental discussion moral standards and the rules concerning current situation assessment.

It is possible to single out four basic bioethics principles: the human dignity respect principle, the personal autonomy recognition principle, the benefaction and no-harm principle ("do good and do no harm!") and the justice principle. There are four rules as well. They consist of the rules of truthfulness, confidentiality, privacy and voluntary informed consent. In total they make up ethical "coordinates" that describe human moral status in social relations system where he finds himself in case of illness.

Human dignity respect principle. In the world around us 2 classes of creatures different in their status exist. In the first place these are creatures similar to us or "humans". In the second place there are animate creatures (animals) as well as inanimate (objects) that are not similar to us. A human can treat animals and inanimate objects as a means of achieving his goals and satisfaction of his needs.

One can kill animals (though the feeling of compassion regards torturing them as inconceivable), eat their meat, use fur and skins for clothes making. A human is in essence excluded from the range of such objects by ancient prohibitions (like cannibalism prohibition) and moral commandments (e.g. by Commandment "Thou shalt not kill"). He *deserves* special treatment in comparison with any other animate beings (not to mention inanimate objects). His *dignity* is inalienable. It does not depend on the race, nationality, development level, physical or social state of human, character traits, vices, merits, etc. Every person owing to being born a human is as it sometimes said a member of moral community or a moral subject. Principles and rules mentioned below should be always applied to him. If a person due to his health condition or age is not able to be up to his high status (e.g. to act as

a subject who can make a moral choice) then his dignity should be protected by others – guardians (e.g. parents) or society representing public organizations and the state.

That is precisely the fact with regard to situations in modern biomedicine that *expresses the principle of respect to human dignity.* In spite of its evidence this principle has not been fulfilled yet. Let's mention just the most important problems of realization of human dignity respect principle.

Carrying out experiments on people without their consent is humiliation of human dignity. It is inadmissible to regard people as laboratory animals ("Guinea pigs"). Article 21 of the Constitution of the Russian Federation reads:

"1. Personality's dignity is protected by the state. Nothing can be the ground for its derogation.

2. Nobody must be subjected to tortures, violence or another cruel or derogating human dignity treatment or punishment. Nobody can make medical, scientific and other experiments on a person without his voluntary consent".

Another sort of human dignity abasement in biomedicine is increasing trend to consider a person (including post mortem) or parts of his body (e.g. organs for transplantation to other people) as an article of trade — an object which can be sold and bought. This is per se the same form of moral impairment as in case of prostitution. A person should not treat himself as an article of trade; he should not permit such treatment on the part of others. The principle of human dignity respect is not only in effect concerning the living but the dead proposing special treatment of dead body.

Personal autonomy recognition principle. The term "autonomy" is derived from Greek words *autos* and *nomos* meaning "oneself" and "law" respectively. In ancient Greece this word had the meaning of self-government of a city-state (polis). In modern philosophy the term "autonomy" was suggested by Immanuel Kant for description of free will that adopts a law of self-action itself. "Autonomy" is different from "heteronomy" which is spurious being of human will when it is guided by external authority for itself as a law (e.g. by the Bible or physician's opinion). In bioethics this term is understood more pragmatically — *a person is recognized as an "autonomous personality" in case he acts independently on the*

basis of rational understanding of his own good. The principle of another person's autonomy recognition does not presume only good attitude towards it. It is necessary to plan and to act in the way so to leave space for an independent responsible act of another person. First of all one should not encroach on his right of making decisions concerning his life himself. A simple idea underlies this principle — person's life and body belong to him. And nobody has the right to use them at his own discretion without appropriate permission.

Traditional medical paternalism directed to a physician to make decisions and act independently ignoring "ignorant" opinion concerning content of patient's personal good. The physician ipso facto deprived a patient of possibility of being a personality, the master of his own body, the "author" of his own biography. It derogates human dignity, puts him in dependency which is not only morally inferior but threatens his vital interests.

The latter is particularly urgent in case of rendering aid to the people differing in moral, cultural or religious principles.

Benefaction and no-harm principle *("do good and do no harm!")* seems self-evident. Isn't it moral to demand from any person in any situation to strive for good and to do himself and others no harm? However this evidence discovers rather complicated problems when it comes to the situations arising in modern biomedicine. It appears that the notions of "good" and "harm" can have different meaning. The matter is whose good and harm it is, how good and harm are evaluated and it depends on specific features of a certain illness.

Good's content varies depending on the fact who evaluates one or another situation. Traditionally it was considered that only physician can impartially assess what is good and what is bad for this patient. A good patient should just fulfill physician's prescriptions responsibly. In modern medicine the situation looks more complicated. The interests of a physician and a patient are not in accord. In the free services distribution systems the fear of needed medical aid deficiency especially medical aid which is hard-to-get is hovering over a patient. In commercially oriented sector of health care the situation is opposite. A physician is interested objectively in "selling" more services. A patient is not now threatened with deficiency of medical treatment but its abundance. In either event the objectivity of

physician's opinion concerning the patient's good can be misinterpreted by his specific interest. In the first case - by the interest in economy of scarce resources (e.g. free medicine). In the second case - by the interest in selling his services profitably. For the conciliation of the interests equal in rights and partnership physician-patient relations are essential. It is necessary for patients to part in determining what is good for them in specific medical cases.

But how can patient's independency become apparent if the physician knows per se the nature of the disease and available methods of its treatment? Answering the question one should not fail to take into consideration several circumstances. In the first place specific physician's knowledge is always limited. Therefore in complicated cases he should seek advice from his colleagues himself. The legislation does not accidentally give patient the right to insist on medical consultations with other physicians. Their assessment of diagnosis, prognosis and optimal method of treatment can differ from the assessment of an attending physician. And usually the problem is not in the fact that one physician knows better than another. Human's organism is just so complicated that it is almost impossible to get a definite answer about illness nature and treatment prospects. As a result of this complication various approaches to rendering medical aid are objectively possible and justified in most cases. Rightful specialization of physicians and medical institutions is based on this idea. Each of physicians evaluates preferable methods of diagnostics and treatment on the basis of his specific previous experience. Simplifying the situation it is possible to say that a surgeon usually prefers a surgical method of treatment and a physician – a therapeutic one. At some medical centres some treatment methods are worked through, in other centres – others are. It is natural that every centre will recommend the methods its personnel is good at or does better than in other institutions.

The patient faces a complicated situation which does not only allows but requires from him independent assessment and the choice of what makes the good in this particular situation.

However let's ask on what grounds can an independent rational choice of the patient be made if in his understanding of his illness biological bases he is completely dependent on the physicians who can disagree with each other besides

other things? The fact is that treatment is not only interference with suffering person's body but a part of physician's as well as patient's life (biography episode). And their common part of live which they live interacting with each other. Therefore a patient can quite rationally trust or not to physician's expert opinion basing on his previous experience of communication with him. If there is no personal experience of communication with specific physician or medical centre then it is possible to receive it from other patients, via the Internet, in numerous organizations of mutual aid of patients suffering various kinds of chronic diseases (cancer, metabolic diseases, asthma, alcohol abuse and drug addiction, mental disorders, diabetes, etc).

In other words under the conditions of treatment methods diversity and different interpretations of expert opinions patient's rational independent choice of his good is based on his critical ability to assess various sources of information, to distinguish reliable opinion from advertisement and self-advertisement.

This is the answer to the question about the possibility of rational understanding of his own good as the ground for respect of his personality.

The same situation is with realization of *no-harm principle.* Since earliest times the principle "Primum non nocere! (first, do no harm!)" exists in medicine. When is it necessary to apply this principle? As in any work one should avoid harm caused by inaction of the person who should provide assistance, by his lack of professionalism, malice or accidental mistakes. So we can speak about fireman's activities, policeman's activities, etc. Besides above mentioned there is own special source of possible harm in medicine.

The point is that any treatment is not accidentally called medical "intervention" into human body activity. Therefore there is always the risk that a physician interfering in organism's vital functions for the purpose of its functions normalization can seriously damage this organism. Quite often this damage is comparable with the good that can be achieved by this intervention. Making a decision on conducting medical, diagnostic or preventive procedure the physician always finds himself forced to weigh benefits and risks associated with specific intervention. In case if alternative methods of rendering aid exist it is necessary to choose those that bear less risk. And the patient is of more importance in modern

medicine while determining the good for the patient as well as evaluating the threat of damaging and making on this basis the decision concerning conducting one or another medical intervention. It is his health and sometimes life that the physician has to risk to achieve one or another good purpose. The legislation does not accidently assign to the physician the obligation to obtain patient's consent to carry out any medical intervention.

The effect of benefaction and no-harm principle should be also referred to mass cases of self-treatment in modern society. If a person doesn't know how healthy is one or another "fashionable" medicine for him he should remember ancient commandment of physicians — Primum non nocere! — and abstain from its intake.

Therefore in modern medicine benefaction and no-harm principle does not only (and sometimes not so much) regulates physician's work morally but expresses an important procedural standard of physician-patient cooperation as equal in rights personalities when attaining common aims as well as person's attitude towards his own corporal wellbeing.

Justice principle. To respect the personality in a specific person also means to treat him fair. The question about justice is one of the most painful questions. Wars, revolutions, social and interpersonal conflicts constantly outbreak because people consider that they are treated unjustly. Fair health-care system is an integrated part of fair law and order.

Formal scheme which one way or another determines general view of almost all ethical interpretations of notion "justice" is the formula ascribed to Aristotle — *equal should be rendered to the equal and unequal should be rendered to the unequal.* But what does it mean to be equal and unequal?

Measures taken for establishing fair relations of equality and inequality of people during distribution are represented in laws and other norms generally adopted in specific society. Therefore the first aspect of evaluation of any act as fair or unfair is associated with its correspondence with the law i.e. with its "legality". However laws are laid down by people and can be estimated themselves as unfair i.e. as protecting the interests of some social groups and infringing the interests of others. For instance if the physician does not provide assistance guaranteed to the patient by law demanding additional fee then he acts unfairly. However if a

legislator declaratively guarantees the whole population free medical aid and at the same time has the salary for physician's highly skilled labor lower than the salary of a janitor in the underground (as it is in Russia) then his act can also be called unfair. *A complicated intertwining of these two forms of injustice makes central the most painful conflict of contemporary Russian health-care system.*

The justice of the law means its *"legitimacy"* But how can laws legitimacy be morally assessed and ensured? Two moral rules exist for this. One is directed to the person who participates in law creation and its discussion in terms of justice. Another points out how the procedure of a new law discussion and its adoption should be ensured morally.

The main claim laid to the person reasoning about justice is the *claim of impartiality.* If I am a sick person suffering from chronic disease then the law giving the maximum of treatment possibilities reflects my interest. If I am a physician who doesn't have only to treat people but to live properly, support a family and bring up children then I'm first of all interested in the law ensuring me with deserved compensation. However the resources are always not enough. Therefore physician-patient conflict is inevitable. How is it possible to approach the solution of this problem fairly?

An important condition of morally appropriate answer to this question is exactly the demand for impartiality. Every person thinking of a fair law should make a moral effort and try to look at this like a man who is not interested in specific outcome of the conflict. American philosopher John Bordley Rawls introduced figurative notion of an "ignorance veil" to characterize impartial attitude of the person judging fairly about a valid norm of good and hardships distribution.

The second moral rule does for assessment of a valid norm for legitimacy from contrary viewpoints. Taking into account moral imperfection of people for whom it is extremely difficult to be impartial it requires adequate representation of all interested in law-making procedure parties. In other words established valid norm (e.g. law) is legitimate if all interested parties involved in one or another social conflict participated equally in its creation and adoption on the basis of democratic procedure.

However laws regulate relations between people in the most general terms. The bulk of real relations is executed by parties' agreements given each other with guarantees and promises. Therefore the notion of justice includes parties' allegiance to accepted obligations. Legitimacy of these obligations is determined by the degree of voluntary participation in it. For example if a patient signs the contract for participation in clinical trials of a new foreign medicine simply because in this case he will be treated free of charge (otherwise he will have to buy medicine himself) then such contract is unfair (not legitimate).

Thus *legality, legitimacy and allegiance to accepted obligations establish formal conditions of assessment of person's activities as fair or unfair.* They help to determine appropriateness and proportionality of the demands coming into conflict with each other — *equality, taking into account of individual needs or individual merits* while distributing scarce resources of health-care and possible hardships.

Four rules of bioethics. Four described above principles determine the most general conditions of attitude towards a patient as a personality. Following the four rules of bioethics provides assistance in their realization. In the first place this is the rule of truthfulness that says "Communicating with patients it is necessary to inform them about illness diagnosis and prognosis, available treatment methods, their possible influence on patient's way and quality of life, patient's rights truthfully, popularly and tactfully".

In the second place let's state the rule of the sanctity of private life (privacy) "Without patient's consent physician should not gather, store and disseminate (pass or sell) the information identifying this person and concerning his private life" the elements of private life are the fact of visiting to a physician, information concerning state of health, biological, psychological and other characteristics, methods of treatment, habits, way of life, etc".

The third rule of confidentiality (the rule of medical secrecy) says "Without patient's permission it is forbidden to hand over information to third parties concerning his health state, way of life and personal qualities as well as the fact of visiting the physician". It is a component of the privacy.

The fourth rule is the already mentioned rule of voluntary informed consent "Any medical intervention should be conducted by patient's consent obtained

voluntarily and on the basis of sufficient awareness of diagnosis and prognosis of illness development considering various variants of treatment and in case of treatment refusal – possible treatment influence on the way and quality of life, of the patient's right to call back his consent".

Taking into account formulated above principles and rules forming theoretical grounds of bioethics is the most important condition of respect towards a patient as a personality.

Chapter 2

ETHICAL GROUNDS FOR RENDERING HUMANITARIAN (INCLUDING MEDICAL) AID IN CONDITIONS OF EMERGENCIES

International Humanitarian Law and Emergencies

International humanitarian law is the whole range of international conventional and usual warfare standards regulating relations between fighting countries and also between them on the one hand and neutral countries on the other hand. Their purpose is the humanization of warfare means and methods. Meanwhile human rights as the sector of international law are the whole range of principles and norms assigned in international documents.

States' obligation to observe a number of principal human rights in any case including periods of armed conflicts was more than once confirmed by decisions of UN General Assembly. "Principle human rights as they are recognized in the international law and stated in international documents continue to be fully applied in case of armed conflict".

Central idea presented in modern acts of international humanitarian law is humanism, respect for human dignity. Their basis is Convention on Human Rights and Fundamental Freedoms (1950), Universal Declaration of Human Rights and

Human Rights Pacts (1966). These documents describe human rights in peacetime first of all. However the principle of respect for the individual is also assumed as its basis.

Military conflicts are particular cases of emergencies. Meanwhile the degree of international humanitarian law application in case of emergencies is not stipulated in special international acts. However the principles and norms of international humanitarian law should be observed in peacetime as well as in armed conflicts period i.e. in case of emergency outbreaking. It means that fundamental human rights and freedoms should be observed by every state irrespective of situation.

In case of emergencies international assistance is often provided to affected country. Such assistance could be humanitarian as well as medical. EMERCOM of Russia rather often provides both kinds of assistance to foreign states in case of emergencies.

Geneva Convention (1949) prohibits offense against human dignity. Meanwhile existent cultural, ethnic, national and first of all religious differences can result in the situation that while providing assistance whether intentionally or not rescuers can infringe upon human dignity of other countries population. In such a multiconfessional country as Russia such situation is possible in some regions of the Russian Federation and even in Moscow.

Physician's Oath and Rendering Medical Aid

The word "illness" in Russian and many other languages is derived from words "pain", "suffering". Perhaps pain syndrome is the most universal syndrome characteristic of most cases of illnesses. In case of emergencies connected with mass injuries pain syndrome can become prevailing.

Suffering caused by pain should arouse compassion in another person especially if this person is a physician. It is no coincidence that compassion and mercy are the principal qualities of a physician. Therefore proceeding from his own vocation a physician can not fail to render medical aid to the victim.

This principle is set in Hippocratic Oath known in Europe "I will apply measures for the benefit of the sick according to my ability and judgment; I will

keep them from harm and injustice". Neither material nor physical condition nor other factors should be the reason for refusing medical aid. The same principle is set in the "Oath of Russian Physician" (1994) "I swear that I will never let personal, religious, national, racial, ethnic, political, economic, social and other non-medical considerations intervene with me and my patient". Physician's oath is included in article 60 of the law "Fundamentals of legislation of the Russian Federation concerning citizens' heath care".

Failure to render medical aid is a criminally prosecuted act. Article 124 of the Penal Code of the Russian Federation reads "Failure to render a sick man medical aid by the person obliged to render it in compliance with the law or with the special rule if it entailed reckless infliction of moderate injury to a sick man is penalized by a fine of 50 to 100 of minimum wage fixing or other income of a convicted person over a one month period of time or by correctional work for the term of one year or by arrest for the term of 2 to for months".

It is interestingly enough that according to eastern medical tradition e.g. in Ayurveda the physician can deny medical aid. Usually such measure is taken to the patients who don't follow medical recommendations or the persons who deliberately inflict damage to their health or practice self-treatment. However the physician does not have the right to deny medical aid in case of emergency.

According to Vedic tradition the physician belongs to the class of Brahmans (intellectuals) what imposes on him moral obligations which are not only his civil duty but also spiritual practice. Meanwhile it is assumed that treatment is fully determined by the physician.

Thereby moral and ethical principles of medicine presuppose that rendering medical aid to all victims is carried out in accordance with physician's competence. This is the moment when the contradiction between humanitarian principles of medicine and the right for freedom of faith of an individual can arise. The reason for it is the fact that almost all religions impose limitations of the amount of medical and paramedical intervention.

It is evident that in case if the situation is not urgent i.e. the possibility of asking a patient about the degree of suggested by the physician acceptable treatment

methods in terms of individual's religious convictions exists. However in urgent situations e.g. in case of emergency such possibility does not exist.

In case of emergency if a patient is not capable of functioning (e.g. is unconscious) article 32 of the Fundamentals of Legislation of the Russian Federation concerning citizens' health protection comes into effect on the territory of the Russian Federation "Consent to medical intervention in respect of the persons who have not reached the age of 15 and the citizens who were legally recognized as legally incapable is given by their legal representatives after being given information provided for the first part of article 31 hereof. In the absence of legal representatives the decision concerning medical intervention is taken by a council of physicians and if it is found impossible to the council to be convened it is taken directly by the attending (duty) physician followed by notification of officials of medioprophilactic institution and legal representatives". In other words the responsibility for the tactics of medical manipulations in urgent cases is as a rule entrusted with a physician.

If the physician has made the right decision then rendered medical aid in case of emergency can benefit patient's body. But if for some reasons conducted measures resulted in infringement of religious interests then the question is left open: to what extent one of the principle medical commandments "do no harm" is observed? I.e. such medical aid can affect unfavourably individual's psychological sphere.

Ethical Peculiarities of Rendering Emergency Medical Aid

Medical aid in emergencies is directed at the good of society at large and should favour the reduction of victims' number. For this purpose triage of victims, phased rendering of medical aid to them as well as antiepidemic measures are organized.

However one should keep in mind that at the same time rights and freedoms of certain victims can be infringed. When carrying out quarantine or evacuation measures their right is restricted as well as the right of their relatives for freedom of

movement. When carrying out phased medical aid the right of a certain patient for rendering medical aid in maximum amount is infringed.

During the triage the danger exists that medical aid will not be rendered in the first place to the persons who mostly need it but to the patients chosen by the person at the triage. Thus during military conflicts men can possess advantage over women for the purpose of returning soldiers to the ranks as soon as possible.

It should be taken into account that regardless of the situation when medical aid is rendered main ethical principles should be observed. These principles are set in such fundamental documents as Nuremberg ethical Code (1947) and Declaration of Helsinki of World Medical Association (1964). New version of these documents was adopted in 2000 in Edinburgh by World Medical Association. Observance of moral norms stated in Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) and in the WMA Statement on Medical Ethics in the Event of Disasters (1994) is of great importance. Sufficient detailed description of bioethical principles and rules was described above.

But the conditions of EMERCOM physicians' activities can impose restrictions on general principles realization.

1. *Human dignity respect principle.* A human deserves special treatment in comparison with other animate beings. This merit is inalienable. It does not depend on race, nationality, religion, social status, clinical diagnosis and other factors. Article 21 of the Constitution of the Russian Federation (1993) reads "Personality's dignity is protected by the state. Nothing can be the ground for its derogation". However rendering medical aid in case of emergency in amount contradicting individual's religious convictions undoubtedly infringes the principle of human's dignity.

2. *Benefaction and no-harm principle.* Rendered medical aid should pursue the good and should not damage individual's health at present as well as in the future. Probable benefit for health while rendering aid should exceed potential risk. Meanwhile medical manipulations being at variance with religious convictions can do moral harm to an individual.

3. *Personal autonomy recognition principle.* A person can be recognized as an independent personality if he consciously agrees with chosen tactics of medical

manipulations. However in case of emergency a person can be unconscious and the time to discuss treatment plan is not enough for a physician. Meanwhile making decision by the physician himself infringes upon the principle of personal autonomy. Thus the physician deprives him of the rights of his own body master, creator of his own biography. It humiliates patient's moral dignity, puts him in subordinate position against the physician and it potentially threatens individual's vital interests. Every person chooses religion himself and acceptability or unacceptability of one or another medical manipulation accordingly. It should be noted that as far back as 1914 the Supreme Court in the USA supported the definition concerning the fact that a surgeon operating on a patient without his consent commits "physical violence and he should compensate the patient for it". The infringement of the personal autonomy principle can be justified only in case of the origination of a threat to society at large (e.g. in case of epidemic explosion threat).

4. *Justice principle* presupposes respect for personality in a man. In case of emergency justice principle is rather often infringed. It is connected with the lack of resources. Meanwhile the demands of equality and taking into account of personal needs or merits are at conflict. To some extent this problem is solvable by means of triage and phased rendering of medical aid. However one should remember that if a sorting person makes the slightest mistake this principle of justice will be infringed.

Thus rendering medical aid based on physician's competence without taking into account individual's religious convictions can result in infringement of at least the first three ethical principles. In other words the question concerning acceptability and amount of rendering medical aid is left open if the possibility of ethical principles infringement of medicine exits.

Let's note that in case of sound organization of urgent medical aid the observance of four basic rules of rendering medical aid is possible to the full: truthfulness, confidentiality, individual right to privacy and voluntary informed consent. However it does not alleviate the problem concerning acceptability of medical aid in emergencies.

Religious Limitations of Amount and Method of Medical Aid Rendering

Almost all religions impose restrictions on victims' dietary habits in emergencies, type of taken medicine and amount of acceptable medical manipulations given in Table 2.

Table 2

BASIC LIMITATIONS OF MEDICAL MANIPULATIONS IMPOSED BY RELIGIONS

Religion	**Patient's Alimentation**	**Taking Medicinal Agents**	**Medical Intervention**
Ayurveda	It is not allowed to eat beef	It is not allowed to give bovine serum-based medicine	No specified restrictions
Buddhism	Determined according to physician's understanding	Determined according to physician's understanding	A number of limitations exists
Judaism	Food should meet the laws of kashruth (should be kosher)	Medicinal agents taken per os should meet the laws of kashruth	A number of limitations exists
Catholicism	Determined according to physician's understanding	Determined according to physician's understanding	A number of limitations exists
Islam	Food should be halal	Taken medicine should be halal	A number of limitations exists; a man cannot examine a woman in the absence of her relatives

Orthodoxy	Determined according to physician's understanding	Determined according to physician's understanding	A number of limitations exists
Protestantism	Determined according to physician's understanding	Determined according to physician's understanding	No specified restrictions

Rendering urgent medical aid based on physician's competence without taking into account religious peculiarities can result in the physician-patient conflict or the conflict between his relatives and the physician. Examples of such conflict situations are reviewed in the next chapter.

The most painful question during rendering medical aid after emergencies is the duration of resuscitation activities. This is due to the fact that modern intensive care progress enables artificial maintaining of life of many victims almost infinitely. World Medical Association (1983) declared that "patient's hope of treatment success even if it is partial does not give the ground for intensive care". However religions' views concerning this question are different (Table 3). Unfortunately the majority of them do not provide a certain criterion for continuation of resuscitation activities.

It should be taken into account that all religions determine certain rules of treating the deceased. In case of emergencies rescuers have to encounter the deceased as the result of disaster as well as the dead despite physician's actions. Infringement of attitude towards the deceased can result in conflict with relatives as well.

Table 3

ATTITUDE OF PRINCIPAL RELIGIONS TOWARDS INTENSIVE CARE

Religion	**Criteria of conducting intensive care**
Ayurveda	Human life should be fought for to the last
Buddhism	It is preferable to let a man die peacefully
Judaism	Physicians (minimum 3 specialists) should together with the family consider all possibilities. If there is at least one chance to save human life it is necessary to conduct intensive care. If resuscitation activities result in fatal outcome and cause suffering and pain intervention should be abstained
Catholicism	It is necessary to assess the benefit for a sick person, the risk he is put at and what subsequent sufferings it can result in. Intensive care is carried out if possible benefit exceeds potential risk.
Islam	Resuscitation is possible if it doesn't threaten patient's life and favours its prolongation
Orthodoxy	Life maintaining after brain death is pointless if it is coupled with somatic disorders
Protestantism	It is necessary to do the best to enable to preserve man's personality

Example 1. After the explosion at Bassmanny market in Moscow the deceased were transported to forensic medical morgue to carry out standard procedure of identifying the bodies. Expert examination could take longer than expected meanwhile religion of the majority of the deceased (Islam) required burial to be

conducted on the day of death. The conflict between authorities and forensic science technicians on the one hand and the relatives of the deceased on the other hand arose. At first special police squad tried to settle this argument but then more reasonable solution was found – religious leaders have been invited. They explained to the relatives that the deceased in the result of emergency would not be less acceptable before Allah if they were not buried on the day of death. Meanwhile a number of experts was increased in order to speed up carrying out of forensic medicine procedures. This compromise made it possible to avoid serious collisions.

Below we present more detailed information concerning main restrictions on medical manipulations imposed by religions.

AYURVEDA

While rendering medical aid to Ayurveda followers physician should on no account cause sufferings to a sick person. He should be patient, attentive, calm, compassionate, and extremely civil especially with women. Physician should not lose his self-control, be arrogant, have overestimated egotism. Neither the patient nor his relatives can be informed of danger of death even if it is real; in any case hope for quick and complete recovery should be given. In any case patient's life should be fought for to the last. The strictest medical secrecy should be kept concerning illness, patient, his life, family, home, etc.

Patients' treatment according to Ayurveda traditions is entirely within physician's competence. Thus the physician has the right to prescribe dietary pattern, means of patient's treatment based on the condition of the latter. However it should be remembered that in India the cow is a sacred animal. Therefore bovine-serum based medicine (some vaccines, serums, epithelizing/regenerating medicine et al) should not be used.

In Ayurveda great attention is given to physician's spiritual qualities. He should be a true believer and give the example of healthy life-style. The physician should know Ayurveda well. Primary importance is not assigned to the healing of body but spiritual healing. Sincere believers can reject physician's services if they consider that he does not correspond to religious canons in his behaviour. "The physician who dresses badly, is rude in his speech, vain, uncivilized and who comes without a call should be avoided by patients"

BUDDHISM

Buddhism denies active euthanasia as well as artificial prolongation of life in case the death could occur without medical apparatus and intensive care. Giving the opportunity of dying peacefully should be preferred to intensive care. However the physician should apply all efforts for saving human life. Induced abortion is forbidden in all cases except the situations when it comes to saving the life of a mother.

Transplantation and hemotransfusion are possible only from living donor provided that it was his gift to the patient (i.e. the donor did not receive money for it). Contraception, prenatal diagnostics, any therapeutic and surgical interventions are permissible.

Abortion, artificial fertilization, cloning and sex reversal are considered as karma breach in Buddhism. These breaches are sinful and inadmissible on no account.

Buddhism does not forbid autopsy. Funeral is carried out according to special ritual on the day stated by lama.

It is interesting that Buddhism enables to decline some religious restrictions if a man's life can be prolonged or his condition can be improved from the point of medical view. In particular fasting can be stopped according to medical recommendations.

It should be remembered that in no case medical aid can be rendered to the person whose legs are directed towards the altar. Even in urgent case the physician should begin rendering aid with changing body position relative to the altar.

JUDAISM

Judaism negates euthanasia even if there is a relevant patient's demand. Meanwhile the opinions of leading religious communities concerning cease of resuscitation activities are different. Orthodox rabbis consider that life should be maintained at any cost; unorthodox consider that in certain cases a man should be allowed to die if his life continuation is associated with considerable physical sufferings that can not end.

According to Judaic tradition a human body is hold in high respect even after his death thus it is not allowed to carry out autopsy (not in all religious schools), to take

organs for transplantation unless the person has himself permitted it and his family has no objections.

In The Talmud the organs arrest or surgical removal of which is fatal are listed. They are brain, heart, lungs, kidneys, liver and pancreatic gland. The Talmud calls them "organs the soul depends on".

In all cases the physician should fight for life to the last breath. In case if impossibility of full physical recovery treatment should be concentrated at abatement of patient's sufferings. It is not allowed to inform the patient of terminal diagnosis.

In terminal cases physicians (minimum 3 specialists) should together with patient's family consider all the possibilities. If there is at least one chance to save human's life it is necessary to conduct intensive care. If resuscitation activities result in fatal outcome and cause suffering and pain intervention should be abstained. But in all cases it is necessary to provide patient with proper care.

Death is certified on the basis of cardiac and respiratory arrest as well as immobility. After the death comes it is necessary to call a rabbi to perform a relevant ceremony.

Blood and organs taking is possible provided that it does not result in deterioration of donor's health condition and is a voluntary act. During organs and blood taking particular attention should be paid to leaving donor's body not mutilated. Orthodox Jews can reject organs transplantation or blood transfusion if the procedure is not sanctified by rabbi.

Induced abortion is inadmissible in all cases. Therapeutic sterilization of a woman is possible but not the one of a man. Artificial fertilization with husband's semen is allowed if other methods of conceiving gave no results.

Saving child's life even if he is one day old or has not yet been born is such an urgent and important task that parents are directed to infringe upon the Sabbath day for its fulfillment. Mother is allowed to carry out surgical operation on the Sabbath day for fetus's saving and postpone circumcision if the infant is ill.

Intake of only kosher (approved by confession) food is allowed. It should meet the laws of kashruth described in detail in the Talmud. Accordingly, all medicine taken per os should be kosher. Life-threatening conditions are the exception. For

the medicine taken parenterally the demand for kosher status is not obligatory. Therefore porcine-based injections and ointments can be used (some orthodox rabbis deny this possibility).

Only the rabbi has the right to give one or another food product kosher status, though this recognition is indispensable to oral medicine. It is more difficult to achieve kosher status due to its animal components. Bovine serum and egg-white used for preparation of vaccines and serums can be kosher only in case if animal's slaughter or breaking eggs were carried out using certain religious retuals. Porcine serum-based medicine can not have kosher status due to the absence of kosher status of the animal itself. Medicine based on raw materials received from fish and mollusks with bone ateliosis and from cartilaginous fish (e.g. sharks) can not have kosher status.

At Easter (Pesach) additional restrictions are placed on food products containing yeast. Accordingly, the patient is no allowed to keep at home and take alcohol-containing medicine. It is not allowed to take BAA containing yeast.

During religious feasts (Sabbath, Yom-Kippur) some restrictions are lifted for seriously ill patients. Thus, during Yom-Kippur food intake can be allowed. Rendering medical aid during Sabbath is permissible only in case if failure to act can result in death or considerable deterioration of patient's health condition.

By Judaic tradition it is admitted that the patient should not resist treatment suggested by the physician. Moreover, the patient should do his best to recover. The decision concerning compulsory treatment can be taken by rabbinate court or a certain rabbi in extreme situations. Rejection of treatment based on religious grounds, e,g, in order not to violate Sabbath, is considered unjustified in Jewish religious tradition. Some rabbis admit the possibility of temporary lifting of most religious restrictions in the face of any danger for human life.

CATHOLICISM

Treating the sick has always been one of special concern of Catholic Church. Catholic Church has always treated with respect useful discoveries and therapeutic agents of medical science using them. Catholicism admits the physician's right for choosing therapeutic approach to patient in terms of his benefit.

Catholic Church takes part in lively debates concerning birth control, sterilization, abortion legitimization, genetic engineering, artificial fertilization, organs and tissues transplantation, euthanasia, abuse of therapeutic agents, sanitary and epidemiologic services of developing countries. Unambiguous solution of the stated problems does not exist.

It is admitted that any medical aid should be concentrated on the saving of life. All medical interventions pursuing this goal (including organs transplantation, hemotransfusion, application of insufficiently known medicine) are acceptable if alternative variants of treatment do not exist.

Therapeutic principle or wholeness principle are at the centre of Catholicism today. Proceeding from it medical or surgical (genetic) intervention is allowed in the cases when it is essential for health recovery or saving of the person as a whole.

Abortion is possible only in therapeutical aspect (threat to mother's life). And in no other situations medicine should regulate conceiving and pregnancy prolongation.

Medical sterilization is prohibited even for the persons with genetic abnormalities, mentally or physically impaired.

Cosmetic or another surgery is acceptable only in case if they are carried out for the purpose of preserving individual's integrity and health or the parts of his/her body.

And medical intervention should be based on the principle of freedom and responsibility: physician's as well as patient's freedom should be united with the responsibility to life and health.

Euthanasia is prohibited in all types and in any circumstances. When choosing intensive care methods it is necessary to assess patient's benefit, risk and possible subsequent sufferings. Intensive care is conducted if possible benefit exceeds potential risk.

ISLAM

According to Islamic religious tradition foetus's soul appears from the first week of the fourth month of pregnancy. Since then abortion is prohibited. Till this time the woman reserves the freedom of choice concerning pregnancy maintenance or abortion. A male physician especially not Muslim ca not examine a woman and

assist in delivery in the absence of her close relatives. Thus when deploying field hospitals on the territory of the Muslim world after emergencies it is necessary to staff physician's complement with female physicians specializing in all fields of medicine. During organizing medical aid to staunch Muslims streams of patients it should be divided in such a way that a male patient and female patient do not find themselves in the same room. Sometimes women's examination by men is allowed in the presence of religious or spiritual leaders.

In case of cerebral death it is allowed to maintain vital functions of other organs by means of artificial ventilation. The possibility of passive euthanasia is negated by Islam. Any intensive care is possible if it does not expose patient's life to danger.

Islam prohibits using any porcine-based food products because this animal is not allowed by religion (it is not halal). Therefore the application of porcine vaccines, serums etc. is not allowed. And the hospital menu should be respectively made. However during fasting Islam tolerates refusal of strict restrictions if it comes to health or life maintenance "If one is sick, nursing or traveling, one is considered exempt from fasting".

Meanwhile Islam admits application of any life saving means "If somebody has revived the deceased it is equal to the fact that he has revived all people". A number of muftis admits that in the event of necessity or emergency the rules of aurat and intersexual ethics are not important because the principal thing is to save life. However orthodox Muslims in any case consider inadmissible taking of porcine serum-based products as well as examination of Muslim women by men in absence if their close relatives.

Islam recognizes artificial fertilization in case the husband's semen is used for it and there is the consent of both spouses. Organs transplantation and hemotransfusion are possible only from live donors professing Islam and who has given consent to it. Transplantation is possible from the person with cerebral death whose respiration and blood circulation are maintained artificially. Kidney, bone marrow, liver (organs capable of regeneration) can be transplanted from live donor. In these cases Islam introduces no limitations; organs transplantation is carried out with no preconditions. Organs for transplantation can be taken from dead foetuses if they are use with therapeutic intentions.

According to Islam demands funeral of the dead should be carried out on the day of his death (till the sunset). It is considered that the persons buried later will not be pleasing to God. Concerning the possibility of autopsy of dead bodies of the deceased the opinions of religious leaders differ.

Sharia as Islam variant does not lay any special claims to medical aid. It just requires from medical workers to fight for patient's life till the last strongly rejecting the possibility of even passive euthanasia. It should be remembered that Sharia followers can differ in the Orthodoxy of their views.

ORTHODOXY

Orthodoxy considers abortion as one of types of murders. Abortion can be allowed only in case mother's life is directly threatened.

Orthodoxy does not recognize contraception outside marriage and in certain cases allows using contraception being married. Methods of family planning are acceptable if the following procreation can affect adversely mother's health or the family is unable to bring up one more child. In any case reversible methods of contraception should be used.

Orthodox Church with certain reservations permits artificial fertilization. Wife's insemination with donor's semen is possible provided that her husband consents. A number of priests forbid and others allow wife's fertilization with husband's semen if other means of conceiving turned out to be unsuccessful.

Orthodoxy does not oppose skin transplantation or hemotransfusion on condition that considerate harm is not caused to donor and if considerable benefit for the patient is attained. Transplantation of other organs is possible only in case donor's life is not threatened.

Death occurs in case of irreversible damage to human tissues. Only after this the intake of organs for transplantation is possible. Before the death the physician should do his best to prolong the life including administering narcotic analgesics, conducting resuscitation activities, surgical interventions, etc. However the majority of Orthodox priests admit that maintaining of life after brain death is pointless if it is coupled with somatic disorders.

In eastern Orthodox tradition it is allowed to appeal God in a prayer to precipitate discarnation if there are no chances for patient's recovery, if his illness

was procrastinated causing considerable sufferings to the person and his relatives. In this case passive but not active euthanasia is allowed.

All in all, Orthodoxy makes the same demands to the physician as to any true believer "Love your neighbour as you love yourself". "The church proceeds from life conceptions concerning life as an invaluable gift of God, inalienable freedom and Godlike dignity of human personality grounded on the Divine Relation".

PROTESTANTISM

Protestantism practically in no way regulates physician's activities just specifying that it should be competent and humane. Thereupon treatment plan is fully determined by attending physician.

Protestantism states that everything possible should be done to let this person remain himsekf for the rest of his life.

Therefore during intensive care a complicated question arises concerning the problem how to preserve human personality better.

Conflict Situations While Rendering Medical Aid in Emergencies

Ignorance of patients' religious peculiarities can not only result in conflicts with relatives but in therapy complications. Let us consider such situations giving several examples.

Example 1. During Ramadan the Muslims observe a strict fast. The same fast is observed by orthodox believers during Holy Week. Accordingly, organism's reaction to minor medical manipulations can be unpredictable. For instance, the patient will answer with faint to local anesthesia.

Example 2. Hemotransfusion without the consent of the patient or his relatives even for his life-saving is a crime in some countries professing Islam including several African countries. Violation of this rule results in criminal liability regardless of the reasons that made the physician resort to such procedure. Even saving patient's life is no excuse for hemotransfusion.

Example 3. In Islamic countries male physician should not see woman's body in absence of her close relatives. After the earthquake in Turkey the rescuers of

EMERCOM of Russia encountered a conflict situation having extricated a woman from under the debris. Her husband tried to kill the wife because other men saw a part of woman's body.

Example 4. Initially the physicians of international organizations came to grief while conducting vaccination programme in Asian countries as the vaccine was made on the basis of European donors' blood. The problem was solved only when using the blood of local population and that of people of consideration mainly elders.

The rescuers of EMERCOM of Russia encountered the same problem. During elimination of consequences of emergencies in India and Indonesia antiepidemic measures were taken. However local population rejected vaccination as the medicine was bovine and porcine serum based. They managed to resolve the conflict by means of involvement of religious leaders and elders who explained the vital necessity of vaccination and the freedom from some religious prohibitions during emergency consequences elimination.

Example 5. Ignorance of patients' religious rights resulted in a number of actions against attending physicians in the USA. All trials ended in favour of the patients. Similar judicial processes were not recorded in the Russian Federation but they can be expected at any moment.

We have carried out the survey among the personnel of Central Airmobile Rescue Team "Tsentrospas" of EMERCOM of Russia in 2006 and 2009 (Table 3). The workers who have taken part in the survey were physicians or rescuers and were male. The workers, who took part in the survey in 2009, had previously taken part in the survey in 2006. The survey consisted of 12 open and closed questions concerning conflict situations while providing medical and humanitarian assistance.

As follows from the table data most part of the respondents encountered various conflict situations and their amount in 2009 in comparison with 2006 has not changed practically. The rescuers who were deployed internationally encountered such conflicts more often. It might be supposed that to date rescuers-local population conflicts are inevitable because of the failure to take into account national, cultural and religious peculiarities

Most frequently the complications in work with local population were connected with the lack of interpreters or lack of knowledge of local language. Therefore rescuers could not explain themselves and explain the necessity of conducting one or another medical or antiepidemic measure. However the respondents had to encounter the cases of acute national rejection. It's rather interesting to note that similar case took place in Yugoslavia. Some of respondents mentioned that in India they observed the same national hostility towards American rescuers.

The rescuers of EMERCOM of Russia commonly enough had to face the difficulties conditional on racial distinctions with local population. Local residents disbelieved in physicians with while-coloured skin. The respondents also encountered the conflicts owing to religion. We can not definitely say whether race conflicts are connected with religious conflicts or not. Usually religious conflicts were recorded in Islamic countries (Iran, Pakistan, Algeria). But they were also recorded in Indonesia, India, on Taiwan.

Mentioned conflict situations reduced the effectiveness of operations of rescuers of EMERCOM of Russia and interfered with their work. The cases of medical aid rejection were recorded and in a number of cases local population completely rejected all kinds of intervention, and in a number of cases they refused any medical aid except for urgent aid. Some representative of local population rejected medical examination, introduction to general anesthesia, therapeutic treatment in absence of their close relatives as well as without approval of their spiritual or religious leaders or elders.

Rescuers looked for various solutions of emerged conflict situations. The majority of them conducted explanatory work with relatives or victims themselves. The minority continued with their work in spite of emerged conflicts or tried to come to agreement with local religious or spiritual leaders as well as elders. Meanwhile the majority of the respondents doubt that they found correct decision in a conflict situation.

In comparison with 2006, in 2009 the number of national and religious conflicts decreased. However the number of cases of medical aid rejection increased. Unfortunately, the number of cases of total rejection of medical aid increased. The

rejection of medical aid due to sex difference, the absence of relatives and religious (spiritual) leaders slightly decreased.

Examples of Conflict Situations

Example 1 (Turkey). After the earthquake the rescuers extricated the woman from under the debris. Her husband tried to kill both the rescuers and the woman; because the non-Muslims saw her naked (her legs were not covered with clothes). From the point of husband's view his wife would better die than a strange man saw her nakedness. They managed to resolve the conflict by means of conversation with community leader.

Example 2 (Indonesia). After the flood 10-year-old girl looks exhausted. Her parents reject to receive physician's consultation because the physician is male. They were explained that examination is needed for establishing diagnosis. They did not manage to resolve the conflict.

Example 3 (Nigeria). Victim's relatives did not like the work of search dog and they stoned it. The relatives considered that the dog profanes the live and the dead. Search operation had to be stopped. The conflict was resolved by means of conversation with relatives.

Example 4 (Russia). After the explosion at the market the deceased were transported to the morgue to carry out forensic expertise as it is prescribed by legal system. The expertise should have taken several days. But some victims' relatives began besetting the morgue requesting to hand them the bodies of the deceased since according to Muslim tradition the deceased should be buried on the day of death. The conflict was resolved by means of muftis' invitation.

Example 5 (Israel). Rejection of therapeutic hemotransfusion occurred because it was unknown if blood belonged to Israelite or not. The conflict was resolved after rabbi's invitation.

Example 6 (India). Refection of preventive bovine blood-based vaccinations was recorded. The conflict was resolved by means of negotiations with local community leaders.

As it follows from above stated data the conflicts while providing assistance after emergencies are rather often recorded. During 3-year observation the frequency of such conflicts did not reduce but the tendency to decreasing of their acuteness began to show. It might be supposed that it is connected with the usage of developed informational materials for rescuers. Hereafter conducting conversations with local community and religious leaders should also be recommended to the rescuers on emergency deployment.

Table 3

CONFLICT SITUATIONS WHEN PROVIDING ASSISTANCE AFTER ENERGENCIES

Situation	Conflict situation mentioning frequency among the respondents, %	
	2006	2009
Various difficulties in working with local population	55.6	50.0
National conflicts	50.0	22.7
• Acute national rejection	2.8	4.5
• Language difficulties	44.4	18.0
• Everyday difficulties	2.8	13.6
Racial conflicts	19.4	9.0
Religious conflicts	41.7	4.5
Cases of patients' rejection of assistance due to emerged conflicts	13.9	22.7
• Total rejection of aid	8.3	13.6
• Rejection of any aid except urgent	5.6	4.5
• Rejection of aid due to sex difference	11.1	9.0
• Rejection of aid in the absence of relatives	5.6	4.5
• Rejection of aid in the absence of religious (spiritual) leaders	11.1	9.0
Search for solution of conflict situation	52.7	63.5
• Conversation with victims	19.4	40.9
• Conversation with victims' relatives	30.6	13.6
• Conversation with religious (spiritual) leaders	2.7	9.0
Found solution of a conflict		
• right	19.4	4.5
• wrong	2.7	4.5
• doubtful	33.3	18.0
The most frequently mentioned countries as the example of the conflict	Turkey, Indonesia, Iran, Algeria, Pakistan	Russia, Israel, Nigeria, India, Taiwan

Rescuers' Health Risks in Case of Emergency Deployment

While providing assistance in other countries after emergencies rescuers in fact find themselves in the place of travellers. According to the data of World Health Organization travelers subject their health to a certain number of risks. Thus the problem arises – to what degree the rescuers of EMERCOM of Russia can risk their health for saving people's lives.

Risk factors for rescuers' health during emergency deployment are:

— the change of climate and time zone;

— endemic infectious diseases;

— stress impact.

Of above-mentioned factors endemic infectious diseases are the most easily staved off. High-efficiency vaccines were developed for the majority of them. However to make the action of the vaccine effective 4-6 weeks should pass after its injection as a rule. In conditions of emergency there is no time to conduct appropriate rescuers' vaccination. Therefore in the high endemic infectious risk areas (Table 4) only the physicians and rescuers with early vaccination should be admitted. However even the 58^{th} vaccination does not guarantee 100% protection from endemic infectious diseases.

Table 4

REGIONS OF HIGH ENDEMIC INFECTION RISK

Disease	**Region**	**Risk for travellers**	**Individual prophylaxis**
Rabies	Worldwide	Increases in endemic regions	Vaccination
Borreliosis	Forest regions of Asia, northwestern, central and eastern Europe, the USA	High in forest regions	Vaccine against serotype spread in the USA is created
Brucellosis	Worldwide; mostly spread in developing countries of the Mediterranean	Low in cities; high in agricultural and rural regions	NA
Hemorrhagic fever	Tropical and subtropical regions; African regions to the south of Sahara desert; steppe regions of central Asia and Europe, south Africa; Saudi Arabia; South America	High in forest and rural regions	NA

Hemophilia meningitis	Worldwide; prevailing in the countries where preventive vaccination is not conducted	Risk is considerable only for persons who were not vaccinated	Vaccination
Hepatitis A	Worldwide, especially in the regions of insufficient water supply and sewerage systems	Risk increases in case of destruction of water supply and sewerage systems; the risk is higher in developing countries в than in civilized ones	Vaccination
Influenza	Worldwide	Risk increases during epidemic	Vaccination is effective only for certain virus strains
Yellow Fever	Tropical regions of Africa, Central and South America	Risk increases during epidemic; risk is higher in rural districts and jungles	Vaccination
Legionellosis	Worldwide	Increases in case of central air conditioning system malfunction	Not available
Leishmaniasis	Countries in tropical and subtropical regions	Increases in rural and forest regions	Not available

Leptospirosis	Prevailing in tropical regions	Increases in rural districts in case of water supply systems damage	Limited application of vaccination
Listeriosis	Worldwide	Low	Not available
Lambliasis	Worldwide	Increases in case of water supply systems damage	Not available
Malaria	Latin America, Caribbean region, the Mediterranean Sea region, Africa, India	Increases in urban and endemic regions	Protection from mosquitoes, chemoprophylaxis
Meningococcosis	Worldwide, prevailing in Africa in the region from Senegal to Ethiopia from November till June	Increases in endemic regions in during seasonal epidemic raise	Vaccine is created against most of the virus strains
Anthrax	Worldwide; mostly in Central Asia	Low	Vaccination
Trypanosomiasis	Tropical regions of Africa; Mexico, South America	Increases in case of visiting rural districts	Not available
Tropical jungle fever	Tropical and subtropical regions of south-eastern Asia, west Africa, Central and South America	Considerable in endemic regions	Usage of mosquito nets; vaccine is unavailable

Filariasis	Africa regions to the south of Sahara, central and western Africa, south-eastern Asia and South America	Considerable in endemic regions	Not available
Cholera	Prevailing in developing countries of Asia, Africa, Central and South America	Low, but in emergency conditions it can increase considerably, especially in case of sewage systems damage	Vaccination
Plague	Eastern and southern Africa, South America, eastern part of North America, part of Asia	Low, increases in case of putting tents in endemic regions	Vaccination
Schistosomiasis	Countries to the south of Sahara desert, Southern Arabia, Brazil, Surinam, Venezuela, China, Indonesia, Philippines, eastern Mediterranean	Increases in case of bathing in water bodies	Not available
Japanese encephalitis	A number of Asian countries, Australia	Risk increases in rural regions	Vaccination

Problem Solution Methods

It is traditionally considered that patient's interest in getting adequate medical aid (preventive, diagnostic, therapeutic, rehabilitation) and physician's responsibility of rendering it coincide. However as it was mentioned above the conflict between the amount of medical aid and individual's religious convictions can arise.

British Medical Association (1963) announced about physician's responsibility for carrying out experiment. It was regulated that the physician before the experiment should ask himself the following questions:

1. Does the patient know what I am going to do with him?
2. Am I able to explain him completely the risk I'm going to expose him to?
3. Am I sure that his consent is voluntary?
4. Will I conduct the procedure if my wife and children were subjected to it?

This decision was one of the fundamental decisions in the ethics of biomedical researches. One should acknowledge that these questions are fully applicable for the case of rendering urgent medical aid. One more question should be added to them:

5. To what extent the aid being rendered corresponds to religious convictions of the victim?

In other words while rendering medical aid it is necessary to try to take into consideration patient's religion, his cultural and other personality traits as far as possible. It should be noted that while rendering medical aid in emergencies and in conditions of mass catastrophes (especially transnational) it is necessary to be careful, explain to victims or their relatives the necessity of every medical intervention and appropriateness of conducting such treatment. On the territory of foreign countries the presence of local physicians familiar with cultural peculiarities of rendering medical aid to population in this very region of the world is advisable.

In modern multipolar world, in the age of man-made disasters and cataclysms operational actions of physicians and rescuers who are often the representatives of various countries are important for rescuing people's lives. The nature of such aid

itself demands from medical society the statement of a new problem concerning the principles of rendering first medical aid taking into account cultural, ethical, religious and other peculiarities. Beyond all doubts, the main burden of concern is laid on the governments of world powers, executive and legislative powers of health-care system and emergencies as well as religious leaders. A strategy should be elaborated about it, probably for every state separately or for entire government regions concerning the principles of rendering first medical aid in emergencies. Meanwhile it is necessary that each participant declares the rules of setting priorities in every particular situation concerning the following question: what is more important – saving human life or observance of religious principles.

Human life is the highest value as it was admitted in many constitutional laws of the states as well as in religious teachings. WHO, UNESCO and many other international organizations for whom humanitarian activities are the basic function using the programme of struggling against principal humanity illnesses posing the health at threat at the global level.

In conditions of emergencies the question concerning the possibility from the point of view of medical ethics arises whether to neglect some or other cultural or religious peculiarities in the name of rescuing people's lives. However in order to make this approach the heritage of professional rescuers the consent at interstate and interreligious level is needed. The principle set by all countries in the world as the document that was adopted by consensus could in the nearest future be expressed in the form of declaration s.v. "Universal Declaration of Ethic Principles of Saving Human Life and Health in XXI century». Relying on the regulations concerning states' responsibility in the field of medicine recorded in Alma Ata declaration (1978) and World Health-Care Declaration as well as in principal objectives of the strategy "Health for Everybody in the XX Century" current stage of realization of this responsibility demands taking relevant measures of social nature particularly in the health-care system. Elaboration of such international document which first of all would concern harmonization of ethical norm while rendering medical aid (it could be a question of consensus elaboration concerning a sort of a partial "delegation" of state and church powers to medical rescuers institution) could be entrusted to UNESCO – the main humanitarian organization in

the world — under the auspices of WHO and many other participants of programmes concerning saving life and health of people. It seems to us that the aim of saving people's lives should be regarded as of paramount importance of such document even if it can lead to digression from certain religious traditions, rules and dogmata.

Chapter 3. Urgent Psychological Aid to the Representatives of Various Cultures in Case of Emergencie

Continuing the conversation about first aid rendering it is impossible to neglect psychological aspects of the condition of people who were injured in emergencies.

Psychological characteristics of emergency are its unexpectedness and swift development, impossibility of accurate development forecast.

The consequences of emergency for people involved in it are changes in their convictions, way of life, psychoemotional and somatic condition.

Rescue services who contact the victims directly (rescue, medical, social services) only to a lesser extent have to do with psychological repercussion of emergency. It happens because this aspect of the problem is not directly the object of their work.

It is evident thereupon that the situation picture of the work of various services involved in rescuing the victims is not full without psychological assistance services operation.

Primary goal of providing psychological assistance to victims is that the people who were not injured in emergency would not be neglected by the services conducting rescue operations. All people who found themselves in emergency situation await help irrespective of their belonging to one or another culture, of the degree of their injury they hope to receive everything they need.

Personal experience of authors' and their colleagues' work with the victims during emergencies on the territory of the Russian Federation as well as abroad shows the presence and manifestation of cultural nonspecific as well as cultural and specific reactions to acute stress among the victims. To cultural nonspecific reactions we attribute the forms and ways of responding which are demonstrated by the representatives of almost all the cultures in emergencies.

Cultural nonspecific reactions apply to psychogenic reactions and symptomatic complexes referring to acute reaction to stress according to International Classification of Diseases (ICD-10 (F43.0), disorder of adaptive

responses (F43.2, except F43.21 – prolonged depressive reaction caused by adaptation disorder), normal reactions of grief Z73.3 (stress condition not classified in other rubrics).

Responding to stress situation are not strictly individual but come to typical enough and become apparent among victims as well as among specialists (in some cases) working in conditions of emergency.

Manifestation of one or another responding style in an intense stress situation with a certain person depends equally on situation peculiarities (intensity and duration of traumatic factor impact), on individual psychological and psychophysiological features of a person, on the level of stress tolerance and presence of positive experience of adequate responding in stress situations.

In modern cultures universal and cultural nonspecific values inherent in various cultures exist uniting all or almost every ethnos. These are the values of life and health. Properly they are not universal but have utmost wide distribution.

The fact that in case of intense stress the representatives of the same cultures and ethnic groups demonstrate similar responding is the evidence of existence of cultural specific reactions. Differences are shown over the situation of conscious emotional regulation; the same is the situation of intense stress.

Therefore the psychologists can not fail to take into account cultural and specific peculiarities of people's responding to intense stress.

Let's designate the main principles of psychologists' work with the representatives of various cultures in emergency.

"Bring no harm" principle. Psychologist should be aware of cultural traditions peculiarities and main religion of the emergency area. Non-judgmental and uncritical specialist's attitude to victim's cultural peculiarities is important.

The specialist should also keep in mind the fugacity of providing assistance, i.e. the assistance should be directed at the correction of patient's actual condition caused by present situation. The psychologist should plan assistance-providing measures taking into account victim's condition and the

period of his stay in emergency area. The stage of psychological assistance should be psychologically completed by the moment of specialist's departure.

The principle of voluntariness implies person's consent to receiving psychological assistance. Usually people address to the specialist with request for psychologist's assistance in emergency situation in field conditions. Before beginning his work the specialist should tactfully specify if the person agrees to psychological assistance and get his confirmation.

Client's interests protection principle. This principle includes professional attitude towards providing assistance. In the period of specialist's work in emergency area from professional point of view he should do all his best for every victim who consulted him separately taking into account client's cultural peculiarities, constantly correlating the methods of his work with the rules of client's cultural environment. The specialist should explain to a person understandably what is he going to do, what will happen to him and get the confirmation that he understood the explanation and agrees. You shouldn't act against person's consent. Client's refusal of some techniques can indicate that client is feeling unwell during the work period, distrusting the specialist or client's situational unreadiness "resistance" for working using suggested methods.

Confidentiality principle. This principle preserves its actuality but it can be broken if client's actions can be dangerous for the client himself or for the people around him.

Professional competence principle. This principle involves first of all the presence of appropriate professional qualification of the psychologist working with victims during emergency. Psychologist should not begin providing assistance in the problem which is beyond his competence (psychiatric, social, legal problems).

In emergencies it is difficult to find another qualified specialist thus it is important for the psychologist to look after his physical and psychoemotional condition, to organize his work-rest schedule rationally, to be able to recover high level of capacity for work using his professional skills.

We call the system of measures which is conducted by specially trained specialists with one person, large or small groups of people in emergency area with the help of means and methods meeting the demands of the situation urgent psychological aid.

Psychological work is divided into:

a) individual;

b) group.

Every person's emotional experience concerning emergency are unique and undoubtedly claim attention of the specialists of special rescue services as well as the specialists of psychological services and sympathy of empathetic people. For one person emergency circumstances can pass without leaving a trace, and such circumstances will leave a mark on another person.

Working in the conditions of emergency with the representatives of various cultures imposes a number of strict restrictions on psychologist's work connected with the necessity of application reliable, universal methods of general functional influence as a rule.

Urgent psychological assistance does not make demands to depth psychotherapy of psychological trauma. It has completely different tasks:

- regulation of actual victims' psychophysiological condition, work with acute reactions to stress (fear, sleep disturbance, mood alterations, etc.);

- working for prevention posttraumatic stress delayed effects (posttraumatic stress disorder).

Therefore the level victim's language knowledge which is good for speaking is enough for psychologist in order to find out complaints, the changes in how he feels, the effect of psychological methods it is possible to make use of interpreters. The psychologist who knows foreign languages can be very useful during doctors' conversation with patients' relatives in the field hospital playing the role of interpreter.

It is important to talk to people, to explain understandably what the specialists are going to do, answer people's questions. Even without knowing some cultural traditions peculiarities of the region the specialist can learn about them during conversation.

Working with children is always a separate and important area of psychologists' work in emergency.

The majority of cases of addressing to psychologists for assistance to children is connected with complaints about fears, heightened anxiety, tension, flashbacks, sleep disorders, dysorexia, capriciousness, mood swings.

As a whole the symptomatology of adult victims' somatic reaction as well as children's, presented by them problems form the clinical presentation described in ICD-10 (F43.0 Adaptation disorders, Acute reaction to stress).

During field hospital deployment being a member of its personnel psychologists have a separate inflatable module for their work also the psychologists possess a special kit for children consisting of sketchbooks, colour pencils, felt pens, toys, development games, construction sets, brain twisters, paints, plasticine, colouring books, balls, balloons.

Psychologists' activities with children include work using children's development games, visual art studies, individual lessons concentrated at reduction of anxiety level, dealing with fear, social adaptation and integration.

Working with children using children's development games, outdoor games, visual art studies, individual lessons contributes to reduction of anxiety level, social adaptation and integration.

Methods of working with children described above are practically universal for the children of all cultures of preschool, primary school and middle school age since they are the means of self-expression for children not affecting their world view, religious and other feelings that have not developed yet.

Restrictions in working with children arise in case of psychotic symptomatology.

More complicated cases, requiring special attention are in working with children in situations when one of his parents or both died. In these cases the psychologists are addressed a request to tell the child about the accident, to give recommendations concerning further behaviour with them.

In this case it is necessary to take into account cultural peculiarities of the people who address to the psychologist. It is necessary to specify with the

adult in the talk how it is appropriate to conduct mourning ceremonies and periods in their country and taking into account received information to develop strategies of work with the child and recommendations for the adults.

It should be absolutely noted that working with the child is inefficient without working with his parents, family, close adults who are around him. Problems with behaviour and the way they feel, symptoms of acute reaction to stress, demonstrated by children, are usually found with adults but as a rule in a more profound form.

Chapter 4 ATTACHMENTS

UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS
19 October 2005
33rd session of the General Conference of UNESCO

The General Conference,

Conscious of the unique capacity of human beings to reflect upon their own existence and on their environment, to perceive injustice, to avoid danger, to assume responsibility, to seek cooperation and to exhibit the moral sense that gives expression to ethical principles.

Reflecting on the rapid developments in science and technology, which increasingly affect our understanding of life and life itself, resulting in a strong demand for a global response to the ethical implications of such developments,

Recognizing that ethical issues raised by the rapid advances in science and their technological applications should be examined with due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Resolving that it is necessary and timely for the international community to state universal principles that will provide a foundation for humanity's response to the ever-increasing dilemmas and controversies that science and technology present for humankind and for the environment,

Recalling the Universal Declaration of Human Rights of 10 December 1948, the Universal Declaration on the Human Genome and Human Rights adopted by the General Conference of UNESCO on 11 November 1997 and the International Declaration on Human Genetic Data adopted by the General Conference of UNESCO on 16 October 2003,

Noting the United Nations International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights of 16 December 1966, the United Nations International Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the United Nations Convention on the Elimination of All Forms of Discrimination against Women of 18 December 1979, the United Nations Convention on the Rights of the Child of 20 November 1989, the United Nations Convention on Biological Diversity of 5 June 1992, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities adopted by the General Assembly of the United Nations in 1993, the UNESCO Recommendation on the Status of Scientific Researchers of 20 November 1974, the UNESCO Declaration on Race and Racial Prejudice of 27 November 1978, the UNESCO Declaration on the Responsibilities of the Present Generations Towards Future Generations of 12 November 1997, the UNESCO Universal Declaration on Cultural Diversity of 2 November 2001, the ILO Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries of 27 June 1989, the International Treaty on Plant Genetic Resources for Food and Agriculture which was adopted by the FAO Conference on 3 November 2001 and entered into force on 29 June 2004, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) annexed to the Marrakech Agreement establishing the World Trade Organization, which entered into force on 1 January 1995, the Doha Declaration on the TRIPS Agreement and Public Health of 14 November 2001 and other relevant international instruments adopted by the United Nations and the specialized agencies of the United Nations system, in

particular the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO),

Also noting international and regional instruments in the field of bioethics, including the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine of the Council of Europe, which was adopted in 1997 and entered into force in 1999, together with its Additional Protocols, as well as national legislation and regulations in the field of bioethics and the international and regional codes of conduct and guidelines and other texts in the field of bioethics, such as the Declaration of Helsinki of the World Medical Association on Ethical Principles for Medical Research Involving Human Subjects, adopted in 1964 and amended in 1975, 1983, 1989, 1996 and 2000 and the International Ethical Guidelines for Biomedical Research Involving Human Subjects of the Council for International Organizations of Medical Sciences, adopted in 1982 and amended in 1993 and 2002,

Recognizing that this Declaration is to be understood in a manner consistent with domestic and international law in conformity with human rights law,

Recalling the Constitution of UNESCO adopted on 16 November 1945,

Considering UNESCO's role in identifying universal principles based on shared ethical values to guide scientific and technological development and social transformation in order to identify emerging challenges in science and technology taking into account the responsibility of the present generations towards future generations, and that questions of bioethics, which necessarily have an international dimension, should be treated as a whole, drawing on the principles already stated in the Universal Declaration on the Human Genome and Human Rights and the International Declaration on Human Genetic Data and taking account not only of the current scientific context but also of future developments,

Aware that human beings are an integral part of the biosphere, with an important role in protecting one another and other forms of life, in particular animals,

Recognizing that, based on the freedom of science and research, scientific and technological developments have been, and can be, of great benefit to humankind in increasing, inter alia, life expectancy and improving the quality of life, and

emphasizing that such developments should always seek to promote the welfare of individuals, families, groups or communities and humankind as a whole in the recognition of the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Recognizing that health does not depend solely on scientific and technological research developments but also on psychosocial and cultural factors,

Also recognizing that decisions regarding ethical issues in medicine, life sciences and associated technologies may have an impact on individuals, families, groups or communities and humankind as a whole,

Bearing in mind that cultural diversity, as a source of exchange, innovation and creativity, is necessary to humankind and, in this sense, is the common heritage of humanity, but emphasizing that it may not be invoked at the expense of human rights and fundamental freedoms,

Also bearing in mind that a person's identity includes biological, psychological, social, cultural and spiritual dimensions,

Recognizing that unethical scientific and technological conduct has had a particular impact on indigenous and local communities,

Convinced that moral sensitivity and ethical reflection should be an integral part of the process of scientific and technological developments and that bioethics should play a predominant role in the choices that need to be made concerning issues arising from such developments,

Considering the desirability of developing new approaches to social responsibility to ensure that progress in science and technology contributes to justice, equity and to the interest of humanity,

Recognizing that an important way to evaluate social realities and achieve equity is to pay attention to the position of women,

Stressing the need to reinforce international cooperation in the field of bioethics, taking into account, in particular, the special needs of developing countries, indigenous communities and vulnerable populations,

Considering that all human beings, without distinction, should benefit from the same high ethical standards in medicine and life science research,

Proclaims the principles that follow and adopts the present Declaration.

GENERAL PROVISIONS

Article 1 – Scope

1. This Declaration addresses ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions.

2. This Declaration is addressed to States. As appropriate and relevant, it also provides guidance to decisions or practices of individuals, groups, communities, institutions and corporations, public and private.

Article 2 – Aims

The aims of this Declaration are:

(a) to provide a universal framework of principles and procedures to guide States in the formulation of their legislation, policies or other instruments in the field of bioethics;

(b) to guide the actions of individuals, groups, communities, institutions and corporations, public and private;

(c) to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law;

(d) to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms;

(e) to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole;

(f) to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries;

(g) to safeguard and promote the interests of the present and future generations;

(h) to underline the importance of biodiversity and its conservation as a common concern of humankind.

PRINCIPLES

Within the scope of this Declaration, in decisions or practices taken or carried out by those to whom it is addressed, the following principles are to be respected.

Article 3 – Human dignity and human rights

1. Human dignity, human rights and fundamental freedoms are to be fully respected.

2. The interests and welfare of the individual should have priority over the sole interest of science or society.

Article 4 – Benefit and harm

In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

Article 5 – Autonomy and individual responsibility

The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

Article 6 – Consent

1. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

2. Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned. The information should be adequate, provided in a comprehensible form and should include modalities for withdrawal of

consent. Consent may be withdrawn by the person concerned at any time and for any reason without any disadvantage or prejudice. Exceptions to this principle should be made only in accordance with ethical and legal standards adopted by States, consistent with the principles and provisions set out in this Declaration, in particular in Article 27, and international human rights law.

3. In appropriate cases of research carried out on a group of persons or a community, additional agreement of the legal representatives of the group or community concerned may be sought. In no case should a collective community agreement or the consent of a community leader or other authority substitute for an individual's informed consent.

Article 7 – Persons without the capacity to consent

In accordance with domestic law, special protection is to be given to persons who do not have the capacity to consent:

(a) authorization for research and medical practice should be obtained in accordance with the best interest of the person concerned and in accordance with domestic law. However, the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent;

(b) research should only be carried out for his or her direct health benefit, subject to the authorization and the protective conditions prescribed by law, and if there is no research alternative of comparable effectiveness with research participants able to consent. Research which does not have potential direct health benefit should only be undertaken by way of exception, with the utmost restraint, exposing the person only to a minimal risk and minimal burden and, if the research is expected to contribute to the health benefit of other persons in the same category, subject to the conditions prescribed by law and compatible with the protection of the individual's human rights. Refusal of such persons to take part in research should be respected.

Article 8 – Respect for human vulnerability and personal integrity

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account.

Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

Article 9 – Privacy and confidentiality

The privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law.

Article 10 – Equality, justice and equity

The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

Article 11 – Non-discrimination and non-stigmatization

No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.

Article 12 – Respect for cultural diversity and pluralism

The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope.

Article 13 – Solidarity and cooperation

Solidarity among human beings and international cooperation towards that end are to be encouraged.

Article 14 – Social responsibility and health

1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.

2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance:

(a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;

(b) access to adequate nutrition and water;

(c) improvement of living conditions and the environment;

(d) elimination of the marginalization and the exclusion of persons on the basis of any grounds;

(e) reduction of poverty and illiteracy.

Article 15 – Sharing of benefits

1. Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms:

(a) special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research;

(b) access to quality health care;

(c) provision of new diagnostic and therapeutic modalities or products stemming from research;

(d) support for health services;

(e) access to scientific and technological knowledge;

(f) capacity-building facilities for research purposes;

(g) other forms of benefit consistent with the principles set out in this Declaration.

2. Benefits should not constitute improper inducements to participate in research.

Article 16 – Protecting future generations

The impact of life sciences on future generations, including on their genetic constitution, should be given due regard.

Article 17 – Protection of the environment, the biosphere and biodiversity

Due regard is to be given to the interconnection between human beings and other forms of life, to the importance of appropriate access and utilization of biological and genetic resources, to respect for traditional knowledge and to the role of human beings in the protection of the environment, the biosphere and biodiversity.

Application of the principles

Article 18 – Decision-making and addressing bioethical issues

1. Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavour should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues.

2. Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis.

3. Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.

Article 19 – Ethics committees

Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to:

(a) assess the relevant ethical, legal, scientific and social issues related to research projects involving human beings;

(b) provide advice on ethical problems in clinical settings;

(c) assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this Declaration;

(d) foster debate, education and public awareness of, and engagement in, bioethics.

Article 20 – Risk assessment and management

Appropriate assessment and adequate management of risk related to medicine, life sciences and associated technologies should be promoted.

Article 21 – Transnational practices

1. States, public and private institutions, and professionals associated with transnational activities should endeavour to ensure that any activity within the scope of this Declaration, undertaken, funded or otherwise pursued in whole or in part in different States, is consistent with the principles set out in this Declaration.

2. When research is undertaken or otherwise pursued in one or more States (the host State(s)) and funded by a source in another State, such research should be the

object of an appropriate level of ethical review in the host State(s) and the State in which the funder is located. This review should be based on ethical and legal standards that are consistent with the principles set out in this Declaration.

3. Transnational health research should be responsive to the needs of host countries, and the importance of research contributing to the alleviation of urgent global health problems should be recognized.

4. When negotiating a research agreement, terms for collaboration and agreement on the benefits of research should be established with equal participation by those party to the negotiation.

5. States should take appropriate measures, both at the national and international levels, to combat bioterrorism and illicit traffic in organs, tissues, samples, genetic resources and genetic-related materials.

PROMOTION OF THE DECLARATION

Article 22 – Role of States

1. States should take all appropriate measures, whether of a legislative, administrative or other character, to give effect to the principles set out in this Declaration in accordance with international human rights law. Such measures should be supported by action in the spheres of education, training and public information.

2. States should encourage the establishment of independent, multidisciplinary and pluralist ethics committees, as set out in Article 19.

Article 23 – Bioethics education, training and information

1. In order to promote the principles set out in this Declaration and to achieve a better understanding of the ethical implications of scientific and technological developments, in particular for young people, States should endeavour to foster bioethics education and training at all levels as well as to encourage information and knowledge dissemination programmes about bioethics.

2. States should encourage the participation of international and regional intergovernmental organizations and international, regional and national non governmental organizations in this endeavour.

Article 24 – International cooperation

1. States should foster international dissemination of scientific information and encourage the free flow and sharing of scientific and technological knowledge.

2. Within the framework of international cooperation, States should promote cultural and scientific cooperation and enter into bilateral and multilateral agreements enabling developing countries to build up their capacity to participate in generating and sharing scientific knowledge, the related know-how and the benefits thereof.

3. States should respect and promote solidarity between and among States, as well as individuals, families, groups and communities, with special regard for those rendered vulnerable by disease or disability or other personal, societal or environmental conditions and those with the most limited resources.

Article 25 – Follow-up action by UNESCO

1. UNESCO shall promote and disseminate the principles set out in this Declaration. In doing so, UNESCO should seek the help and assistance of the Intergovernmental Bioethics Committee (IGBC) and the International Bioethics Committee (IBC).

2. UNESCO shall reaffirm its commitment to dealing with bioethics and to promoting collaboration between IGBC and IBC.

FINAL PROVISIONS

Article 26 – Interrelation and complementarity of the principles

This Declaration is to be understood as a whole and the principles are to be understood as complementary and interrelated. Each principle is to be considered in the context of the other principles, as appropriate and relevant in the circumstances.

Article 27 – Limitations on the application of the principles

If the application of the principles of this Declaration is to be limited, it should be by law, including laws in the interests of public safety, for the investigation, detection and prosecution of criminal offences, for the protection of public health or for the protection of the rights and freedoms of others. Any such law needs to be consistent with international human rights law.

Article 28 – Denial of acts contrary to human rights, fundamental freedoms and human dignity

Nothing in this Declaration may be interpreted as implying for any State, group or person any claim to engage in any activity or to perform any act contrary to human rights, fundamental freedoms and human dignity.

Statement on Medical Ethics in the Event of Disasters

Adopted by the 46th WMA General Assembly Stockholm, Sweden, September 1994 г.

1. The definition of a disaster for the purpose of this document focuses particularly on the medical aspects. A disaster is the sudden occurrence of a calamitous, usually violent, event resulting in substantial material damage, considerable displacement of people, a large number of victims and/or significant social disruption. This definition excludes situations arising from conflicts and wars, whether international or internal, which give rise to other problems in addition to those considered in this paper. From the medical standpoint, disaster situations are characterized by an acute and unforeseen imbalance between the capacity and resources of the medical profession and the needs of survivors who are injured whose health is threatened, over a given period of time.

2. Disasters, irrespective of cause, share several features:

a) their sudden and unexpected occurrence, demanding prompt action;

b) material or natural damage making access to the survivors difficult and/or dangerous;

c) adverse effects on health due to pollution, and the risks of epidemics, and emotional and psychological factors;

d) a context of insecurity requiring police or military measures to maintain order;

e) media coverage.

Disasters require multifaceted responses involving many different types of relief ranging from transportation and food supplies to medical services. Physicians are likely to be part of coordinated operations involving other responders such as law enforcement personnel. These operations require an effective and centralized authority to coordinate public and private efforts. Rescue workers and physicians are confronted with an exceptional situation in which their normal professional ethics must be brought to the situation to ensure that the treatment of disaster survivors conforms to basic ethical tenets and is not influenced by other motivations. Ethical rules defined and taught beforehand should complement the individual ethics of physicians.

Inadequate and/or disrupted medical resources on site and the large number of people injured in a short time present specific ethical challenges.

The World Medical Association therefore recommends the following ethical principles and procedures with regard to the physician's role in disaster situations.

3. Triage

3.1 Triage is a medical action of prioritizing treatment and management based on a rapid diagnosis and prognosis for each patient. Triage must be carried out systematically, taking into account the medical needs, medical intervention capabilities and available resources. Vital acts of reanimation may have to be carried out at the same time as triage. Triage may pose an ethical problem owing to the limited treatment resources immediately available in relation to the large number of injured persons in varying states of health.

3.2 Ideally, triage should be entrusted to authorized, experienced physicians or to physician teams, assisted by a competent staff.

3.3 The physician should separate patients into categories and then treat them in the following order, subject to national guidelines:

a) patients who can be saved but whose lives are in immediate danger should be given treatment straight away or as a matter of priority within the next few hours;

b) patients whose lives are not in immediate danger and who are in need of urgent but not immediate medical care should be treated next;

c) injured persons requiring only minor treatment can be treated later or by relief workers;

d) psychologically traumatized individuals who do not require treatment for bodily harm but might need reassurance or sedation if acutely disturbed;

e) patients whose condition exceeds the available therapeutic resources, who suffer from extremely severe injuries such as irradiation or burns to such an extent and degree that they cannot be saved in the specific circumstances of time and place, or complex surgical cases requiring a particularly delicate operation which would take too long, thereby obliging the physician to make a choice between them and other patients. Such patients may be classified as "beyond emergency care".

d) since cases may evolve and thus change category, it is essential that the situation be regularly reassessed by the official in charge of the triage.

3.4 The following statements apply to treatment beyond emergency care:

a) it is ethical for a physician not to persist, at all costs, in treating individuals "beyond emergency care", thereby wasting scarce resources needed else-where. The decision not to treat an injured person on account of priorities dictated by the disaster situation cannot be considered a failure to come to the assistance of a person in mortal danger. It is justified when it is intended to save the maximum number of individuals. However, the physician must show such patients compassion and respect for their dignity, for example by separating them from others and administering appropriate pain relief and sedatives.

b) The physician must act according to the needs of patients and the resources available. He/she should attempt to set an order of priorities for treatment that will save the greatest number of lives and restrict morbidity to a minimum.

4. Relations with the patients

4.1 The victims are rendered primary and emergency health care. In case of catastrophes and disasters the physician should impartially come to every victim aid without a request for it.

4.2 In selecting the patients who may be saved, the physician should consider only their medical status, and should exclude any other consideration based on non-medical criteria.

4.3 The attitude towards the victims is determined by their need in rendering primary medical aid meanwhile the main principle should be observed to the possible extent – protection of patient's rights. Nevertheless the physician should take into account various cultural orientations of his patients and act in compliance with the situation. The physician should follow the conception of rendering optimal medical aid in order to save maximum amount of lives and minimize the mortality rate.

4.4 Physician-patient relations also include such aspects as sorrow at the deceased, recognition and providing support to those in condition of psychological distress that can not be referred to merely technical medical intervention; respectful attitude towards the dignity and moral principles of the victims and members of their family and necessity to lend them a helping hand also applies to it.

4.5 The physician must respect the customs, rites and religions of the patients and act in all impartiality.

4.6 As far as possible in spite of existing difficulties it is necessary to identify the victims passing the information to the following team.

Survivors of a disaster are entitled to the same respect as other patients, and the most appropriate treatment available should be administered with the patient's consent. However, it should be recognized that in a disaster response there may not be enough time for informed consent to be a realistic possibility.

5. Other third parties

The physician has a duty to each patient to exercise discretion and ensure confidentiality when dealing with third parties, and to exercise caution and objectivity and act with dignity with respect to the emotional and political atmosphere surrounding disaster situations.

6. Duties of paramedical personnel

The ethical principles that apply to physicians also apply to personnel under the physician's direction.

7. Training

The World Medical Association recommends that disaster medicine training be included in the curricula of university and post-graduate courses in medicine.

8. Responsibility

The World Medical Association calls upon governments and insurance companies to cover both civil liability and any personal damages to which physicians might be subject when working in disaster or emergency situations.

The WMA requests that governments:

a) accept the presence of foreign physicians and, where demonstrably qualified, their participation, without discrimination on the basis of factors such as affiliation (e.g. Red Cross, Red Crescent, ICRC, and other qualified organizations), race, or religion.

b) give priority to the rendering of medical services over visits of dignitaries.

ETHICAL PROBLEMS OF MEDICAL ASSISTANCE IN EMERGENCY SITUATIONS

Abstract

In the century of cataclysms and technogenic catastrophes the joint participation of physicians from different countries plays essential role in the provision of medical aid in zones of disasters. However, at present in different countries of world there are unequal approaches to the provision of medical aid to victims. As a result, the aid permitted into some countries. it proves to be unacceptable for the representatives of other countries or religious groups. Similar problems could arise not only in international actions of disaster relief, but also in management of relief aid inside such multinational and multicultural country as the Russian Federation.

The proposed to the attention of the reader brochure is built as step by step passage from the general bioethical principles of medical practice in modern world to its special norms in medical assistance in emergency situations. After the brief description of the concept of emergency situation, system of universal ethical rules and principles of physician-patient relations is presented. These principles and rules are included in many international and national ethical codes of medical activity. The Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) is the most characteristic example. The next part of the brochure presents complexity of applying universal rules and principles to exact situations of medical assistance in emergency situations to victims, who represent different ethnic and religious groups. Specific cultural and religious values that governs physician — patient relationships in Judaism, Islam, Buddhism and main Christian confessions are discussed. The brochure also gives information about exact cases of serious problems that took place because medical professionals were ignorant about specific cultural and religious values of their patients. It contains practical recommendations on proper, sensitive to cultural differences conduct of medical professional in zones of catastrophes. Medical aid in emergency situations is an essential part of complex humanitarian assistance. That is why; brochure also gives information about on basic international standards of humanitarian disaster relief operations. In appendix texts of The Universal Declaration on Bio- ethics and Human Rights (UNESCO, 2005), and World Medical Association Declaration (Stockholm 1994) are given.

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